



COUNTY OF LOS ANGELES EMERGENCY MEDICAL SERVICES COMMISSION

10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
(562) 347-1604 FAX (562) 941-5835
<http://.ems.dhs.lacounty.gov/>

Los Angeles County Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Commissioners

Mr. David Austin

LA County Ambulance Association
Chief Robert E. Barnes
Los Angeles County Police Chiefs Assn.

Mr. Frank Binch

Public Member (4th District)

Erick H. Cheung, M.D.

Southern CA Psychiatric Society

Robert Flashman, M.D.

LA County Medical Association

Clayton Kazan, M.D.

California Chapter-American College of
Emergency Physicians (CAL-ACEP)

Mr. James Lott

Public Member (2nd District)

Chief Raymond A. Mosack, Chair
CA State Firefighters' Association

Mr. Daryl Parrish

League of Calif. Cities/LA County Division

Capt. Andres Ramirez

Peace Officers Association of LA County

Nurses Sanossian, MD, FAHA

American Heart Association

Western States Affiliate

Carole A. Snyder, RN, Vice Chair

Emergency Nurses Association

Chief Jon D. Thompson

LA Chapter-Fire Chiefs Association

Areti Tillou, M.D.

LA Surgical Society

Mr. Gary Washburn

Public Member (5th District)

Mr. Bernard S. Weintraub

Southern California Public Health Assn.

VACANT

Hospital Association of Southern CA

Public Member (1st District)

Public Member (3rd District)

Executive Director

Cathy Chidester

Director, EMS Agency
(562) 347-1604

cchidester@dhs.lacounty.gov

Commission Liaison

Marilyn Rideaux

(323) 890-7392

mr Rideaux@dhs.lacounty.gov

DATE: November 19, 2014

TIME: 1:00 – 3:00 pm

LOCATION: Los Angeles County EMS Agency
10100 Pioneer Blvd.
EMS Commission Hearing Room – 1st Floor
Santa Fe Springs, CA 90670

The Commission meetings are open to the public. You may address the Commission on any agenda item before or during consideration of that item, and on other items of interest which are not on the agenda, but which are within the subject matter jurisdiction of the Commission. Public comment is limited to three (3) minutes and may be extended by Commission Chair as time permits.

NOTE: Please SIGN IN if you would like to address the Commission.

AGENDA

CALL TO ORDER – Raymond Mosack, Chairman

INTRODUCTIONS/ANNOUNCEMENTS

CONSENT CALENDAR (Commissioners/Public may request that an item be held for discussion.)

1 MINUTES

- July 16, 2014
- No official meeting on September 17, 2014 due to lack of a quorum

2 CORRESPONDENCE

- 2.1 October 27, 2014, Ralph Mundell, Fire Chief, Beverly Hills Fire Department: Utilization of QuikClot® Combat Gauze™
- 2.2 October 27, 2014, Ralph Terrazas, Fire Chief, Los Angeles Fire Department: Utilization of QuikClot® Combat Gauze™
- 2.3 October 23, 2014, Cathy Chidester/EMS Commission: Letter of Resignation from the EMS Commission from Mr. Gerald Clute
- 2.4 October 20, 2014, Harold Scoggins, Fire Chief, Glendale Fire Department: Newly Appointed Medical Director
- 2.5 October 8, 2014, Doug Cain, Executive Vice President, Antelope Ambulance Service: Request to split an existing Exclusive Operating Area (EOA) for the 2016 Emergency Ambulance Transportation Agreements
- 2.6 October 6, 2014, Dan Castillo, Chief Executive Officer, LAC+USC Medical Center: Allocation of Senate Bill 1773, Pediatric Trauma Center Funding (Richie's Fund) for Fiscal Year 2013-2014
- 2.7 October 6, 2014, Thomas M. Priselac, President/CEO, Cedars-Sinai Medical Center: Allocation of Senate Bill 1773, Pediatric Trauma Center Funding (Richie's Fund) for Fiscal Year 2013-2014

- 2.8 October 6, 2014, Delvecchio Finley, Chief Executive Officer, Harbor-UCLA Medical Center: Allocation of Senate Bill 1773 Pediatric Trauma Center Funding (Richie's Fund) for Fiscal Year 2013-2014
- 2.9 October 6, 2014, Diana Hendel, Chief Executive Officer, Long Beach Memorial Medical Center: Allocation of Senate Bill 1773 Pediatric Trauma Center Funding (Richie's Fund) for Fiscal Year 2013-2014
- 2.10 October 6, 2014, Saliba Salo, President, Northridge Hospital Medical Center: Allocation of Senate Bill 1773 Pediatric Trauma Center Funding (Richie's Fund) for Fiscal Year 2013-2014
- 2.11 October 6, 2014, Richard D. Cordova, President/CEO, Children's Hospital Los Angeles: Allocation of Senate Bill 1773 Pediatric Trauma Center Funding (Richie's Fund) for Fiscal Year 2013-2014
- 2.12 October 6, 2014, Shannon O'Kelley, Chief Operating Officer, UCLA Medical Center: Allocation of Senate Bill 1773 Pediatric Trauma Center Funding (Richie's Fund) for Fiscal Year 2013-2014
- 2.13 October 6, 2014, (Distribution): Update on Ebola Virus Disease (EVD) For EMS
- 2.14 September 25, 2014, (Distribution): Normal Saline Intravenous Solution Shortage
- 2.15 September 25, 2014, (Distribution): Dopamine Shortage/Countywide Utilization
- 2.16 Medical Director, All 9-1-1 Receiving Facilities, All 9-1-1 Provider Agencies: Senior Physician Opening at Emergency Medical Services Agency

(The following Correspondence was carried over from the 9-17-14 agenda)

- 2.17 August 14, 2014, Each Supervisor: Emergency Medical Services Commission Annual Report – FY 2013/2014
- 2.18 August 11, 2014, Jim Branchick, Chief Executive Officer, Kaiser Foundation-Downey Medical Center: Designation as an Approved Stroke Center (ASC)
- 2.19 August 7, 2014, Tom Lenahan, Fire Chief, Burbank Fire Department: Approved for expanded utilization of intraosseous (IO) infusion for hypoperfusing pediatric and adult patients
- 2.20 August 6, 2014, Distribution: Pre-Positioned Antibiotics
- 2.21 July 24, 2014, Gloria J. Robertson, Office of Statewide Health Planning and Development: Health Workforce Pilot Project Application #173
- 2.22 July 21, 2014, Michael DuRee, Fire Chief, Long Beach Fire Department: Unit Reconfiguration – Approval
- 2.23 July 21, 2014, Administrator, Each Los Angeles County Skilled Nursing Facility: Accessing Emergency Medical Transportation

3. COMMITTEE REPORTS

- 3.1 Base Hospital Advisory Committee
- 3.2 Data Advisory Committee
- 3.3 Education Advisory Committee
- 3.4 Provider Agency Advisory Committee

4. POLICIES

- 4.1 Reference No. 206, Emergency Medical Services Commission - Ordinance No. 12332 – Chapter 3.20 of the Los Angeles County Code
- 4.2 Reference No. 406, Authorization for Paramedic Provider Status
- 4.3 Reference No. 410, Drug Authorizing Physician for Provider Agencies
- 4.4 Reference No. 418, Authorization and Classification of EMS Aircraft

- 4.5 Reference No. 418.1, EMS Aircraft Application
- 4.6 Reference No. 506, Trauma Triage
- 4.7 Reference No. 514, Prehospital EMS Aircraft Operations
- 4.8 Reference No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles
- 4.9 Reference No. 806.1, Procedures Prior to Base Contact

(For information only)

- 4.10 Reference No. 410.1, Provider Agency Drug Authorizing Physician Confirmation of Agreement to Purchase Drugs and Medical Supplies
- 4.11 Reference No. 451.1a, Ambulance Vehicle Essential Medical Equipment
- 4.12 Reference No. 703, ALS Unit Inventory
- 4.13 Reference No. 706, ALS EMS Aircraft Inventory
- 4.14 Reference No. 1212, Treatment Protocol: Symptomatic Bradycardia (Adult)
- 4.15 Reference No. 1223, Treatment Protocol: Decompression Emergency
- 4.16 Reference No. 1242, Treatment Protocol: Allergic Reaction/Anaphylaxis
- 4.17 Reference No. 1244, Treatment Protocol: Chest Pain
- 4.18 Reference No. 1246, Treatment Protocol: Non-Traumatic Hypotension
- 4.19 Reference No. 1249, Treatment Protocol: Respiratory Distress
- 4.20 Reference No. 1318, Medical Control Guideline: Intraosseous Access

BUSINESS

Old:

- 5.1 Community Paramedicine (*July 18, 2012*)
- 5.2 Wall Time (*July 17, 2013*)
- 5.3 Active Shooter
- 5.4 Request For Proposal (RFP) for Emergency Ambulance Transportation (*July 16, 2014*)
- 5.5 Physician Services for Indigent Program (PSIP) – Proposed Reimbursement Rate Increase for Services Provided in FY 2014/2015 (*September 17, 2014*) – **Attachments (3)**
 - *August 14, 2014, Participating and New Enrollment Physicians: Physician Services for Indigents Program Enrollment Deadlines by Fiscal Year*
 - *August 14, 2014, Distribution: Physician Services for Indigents Program Notice of Proposed Reimbursement Rate Increase for Services Provided in Fiscal Year 2014-15*
 - *October 6, 2014, Each Supervisor: Revised Reimbursement Rates For Physician Services For Indigents Program (PSIP)*
- 5.6 1+1 Paramedic Staffing Model (*November 21, 2012*) – **Attachments (3)**
 - *July 3, 2014, Stephen R. Shea, Medical Director, Long Beach Fire Department: Utilization of Standing Field Treatment Protocols (SFTP)*
 - *October 22, 2014, Michael Duree, Fire Chief, City of Long Beach Fire Department: Request for written plan for improvement to the Rapid Medic Deployment pilot project*
 - *October 28, 2014, Cathy Chidester, Director, EMS Agency: Reference 407 requirement for on scene arrival of first and second unit*

New:

- 5.7 911 EMS Provider Ebola Virus Disease (EVD) Patient Assessment and Transportation Guidelines – **Attachment (1)**

- *Guidance on Transfer of Care of Suspect Ebola Virus Disease (EVD)
Patient Transported by Ambulance*

5.8 Conducting Public Meetings In Accordance With The Brown Act

5.9 Appointment of a Nominating Committee

6. COMMISSIONERS COMMENTS/REQUESTS

7. LEGISLATION

8. EMS DIRECTOR'S REPORT

- Data Reports
- Trauma Center in the East San Gabriel Valley
- Motion by Supervisor Mark Ridley Thomas regarding training all employees to perform Hands Only CPR
- Motion by Supervisor Mark Ridley Thomas regarding sale of St. Francis Medical Center and Martin Luther King, Jr., Community Hospital

9. ADJOURNMENT

(To the meeting of January 21, 2015)

Lobbyist Registration: Any person or entity who seeks support or endorsement from the EMS Commission on official action must certify that they are familiar with the requirements of Ordinance No. 93-0031. Persons not in compliance with the requirements of the Ordinance shall be denied the right to address the Commission for such period of time as the noncompliance exists.

CONSENT CALENDAR

November 19, 2014

1. MINUTES

- July 16, 2014

2. CORRESPONDENCE

- 2.1 October 27, 2014, Ralph Mundell, Fire Chief, Beverly Hills Fire Department: Utilization of QuikClot® Combat Gauze™
 - 2.2 October 27, 2014, Ralph Terrazas, Fire Chief, Los Angeles Fire Department: Utilization of QuikClot® Combat Gauze™
 - 2.3 October 23, 2014, Cathy Chidester/EMS Commission: Letter of Resignation from the EMS Commission from Mr. Gerald Clute
 - 2.4 October 20, 2014, Harold Scoggins, Fire Chief, Glendale Fire Department: Newly Appointed Medical Director
 - 2.5 October 8, 2014, Doug Cain, Executive Vice President, Antelope Ambulance Service: Request to split an existing Exclusive Operating Area (EOA) for the 2016 Emergency Ambulance Transportation Agreements
 - 2.6 October 6, 2014, Dan Castillo, Chief Executive Officer, LAC+USC Medical Center: Allocation of Senate Bill 1773, Pediatric Trauma Center Funding (Richie's Fund) for Fiscal Year 2013-2014
 - 2.7 October 6, 2014, Thomas M. Priselac, President/CEO, Cedars-Sinai Medical Center: Allocation of Senate Bill 1773, Pediatric Trauma Center Funding (Richie's Fund) for Fiscal Year 2013-2014
 - 2.8 October 6, 2014, Delvecchio Finley, Chief Executive Officer, Harbor-UCLA Medical Center: Allocation of Senate Bill 1773 Pediatric Trauma Center Funding (Richie's Fund) for Fiscal Year 2013-2014
 - 2.9 October 6, 2014, Diana Hendel, Chief Executive Officer, Long Beach Memorial Medical Center: Allocation of Senate Bill 1773 Pediatric Trauma Center Funding (Richie's Fund) for Fiscal Year 2013-2014
 - 2.10 October 6, 2014, Saliba Salo, President, Northridge Hospital Medical Center: Allocation of Senate Bill 1773 Pediatric Trauma Center Funding (Richie's Fund) for Fiscal Year 2013-2014
 - 2.11 October 6, 2014, Richard D. Cordova, President/CEO, Children's Hospital Los Angeles: Allocation of Senate Bill 1773 Pediatric Trauma Center Funding (Richie's Fund) for Fiscal Year 2013-2014
 - 2.12 October 6, 2014, Shannon O'Kelley, Chief Operating Officer, UCLA Medical Center: Allocation of Senate Bill 1773 Pediatric Trauma Center Funding (Richie's Fund) for Fiscal Year 2013-2014
 - 2.13 October 6, 2014, (Distribution): Update on Ebola Virus Disease (EVD) For EMS
 - 2.14 September 25, 2014, (Distribution): Normal Saline Intravenous Solution Shortage
 - 2.15 September 25, 2014, (Distribution): Dopamine Shortage/Countywide Utilization
 - 2.16 Medical Director, All 9-1-1 Receiving Facilities, All 9-1-1 Provider Agencies: Senior Physician Opening at Emergency Medical Services Agency
- (The following Correspondence was carried over from the 9-17-14 agenda)*
- 2.17 August 14, 2014, Each Supervisor: Emergency Medical Services Commission Annual Report – FY 2013/2014
 - 2.18 August 11, 2014, Jim Branchick, Chief Executive Officer, Kaiser Foundation-Downey Medical Center: Designation as an Approved Stroke Center (ASC)

- 2.19 August 7, 2014, Tom Lenahan, Fire Chief, Burbank Fire Department: Approved for expanded utilization of intraosseous (IO) infusion for hypoperfusing pediatric and adult patients
- 2.20 August 6, 2014, Distribution: Pre-Positioned Antibiotics
- 2.21 July 24, 2014, Gloria J. Robertson, Office of Statewide Health Planning and Development: Health Workforce Pilot Project Application #173
- 2.22 July 21, 2014, Michael DuRee, Fire Chief, Long Beach Fire Department: Unit Reconfiguration – Approval
- 2.23 July 21, 2014, Administrator, Each Los Angeles County Skilled Nursing Facility: Accessing Emergency Medical Transportation

3. **COMMITTEE REPORTS**

- 3.1 Base Hospital Advisory Committee
- 3.2 Data Advisory Committee
- 3.3 Education Advisory Committee
- 3.4 Provider Agency Advisory Committee

4. **POLICIES**

- 4.1 Reference No. 206, Emergency Medical Services Commission - Ordinance No. 12332 – Chapter 3.20 of the Los Angeles County Code
- 4.2 Reference No. 406, Authorization for Paramedic Provider Status
- 4.3 Reference No. 410, Drug Authorizing Physician for Provider Agencies
- 4.4 Reference No. 418, Authorization and Classification of EMS Aircraft
- 4.5 Reference No. 418.1, EMS Aircraft Application
- 4.6 Reference No. 506, Trauma Triage
- 4.7 Reference No. 514, Prehospital EMS Aircraft Operations
- 4.8 Reference No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles
- 4.9 Reference No. 806.1, Procedures Prior to Base Contact

(For information only)

- 4.10 Reference No. 410.1, Provider Agency Drug Authorizing Physician Confirmation of Agreement to Purchase Drugs and Medical Supplies
- 4.11 Reference No. 451.1a, Ambulance Vehicle Essential Medical Equipment
- 4.12 Reference No. 703, ALS Unit Inventory
- 4.13 Reference No. 706, ALS EMS Aircraft Inventory
- 4.14 Reference No. 1212, Treatment Protocol: Symptomatic Bradycardia (Adult)
- 4.15 Reference No. 1223, Treatment Protocol: Decompression Emergency
- 4.16 Reference No. 1242, Treatment Protocol: Allergic Reaction/Anaphylaxis
- 4.17 Reference No. 1244, Treatment Protocol: Chest Pain
- 4.18 Reference No. 1246, Treatment Protocol: Non-Traumatic Hypotension
- 4.19 Reference No. 1249, Treatment Protocol: Respiratory Distress
- 4.20 Reference No. 1318, Medical Control Guideline: Intraosseous Access



COUNTY OF LOS ANGELES EMERGENCY MEDICAL SERVICES COMMISSION

10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
(562) 347-1604 FAX (562) 941-5835
<http://.ems.dhs.lacounty.gov/>

**Los Angeles County
Board of Supervisors**

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Commissioners

Mr. David Austin

LA County Ambulance Association

Chief Robert E. Barnes

Los Angeles County Police Chiefs Assn.

Mr. Frank Binch

Public Member (4th District)

Erick H. Cheung, M.D.

Southern CA Psychiatric Society

Mr. Gerald B. Clute

Hospital Association of Southern CA

Robert Flashman, M.D.

LA County Medical Association

(VACANT)

Public Member (3rd District)

Clayton Kazan, M.D.

California Chapter-American College of
Emergency Physicians (CAL-ACEP)

Chief Raymond A. Mosack, Chair

CA State Firefighters' Association

Mr. Daryl Parrish

League of Calif. Cities/LA County Division

Capt. Andres Ramirez

Peace Officers Association of LA County

Nurses Sanossian, MD, FAHA

American Heart Association

Western States Affiliate

Carole A. Snyder, RN, Vice Chair

Emergency Nurses Association

Chief Jon D. Thompson

LA Chapter-Fire Chiefs Association

Areti Tillou, M.D.

LA Surgical Society

Mr. Gary Washburn

Public Member (5th District)

Mr. Bernard S. Weintraub

Southern California Public Health Assn.

VACANT

Public Member (1st District)

Public Member (2nd District)

Executive Director

Cathy Chidester

Director, EMS Agency

(562) 347-1604

cchidester@dhs.lacounty.gov

Commission Liaison

Marilyn Rideaux

(323) 890-7392

mr Rideaux@dhs.lacounty.gov

MINUTES July 16, 2014

COMMISSIONERS	ORGANIZATION	EMS AGENCY STAFF	POSITION
<input checked="" type="checkbox"/> David Austin	LAC Ambulance Assn	Cathy Chidester	Director, EMS
<input checked="" type="checkbox"/> Robert Barnes	LAC Police Chiefs Assn	Marilyn Rideaux	EMSC Liaison
Frank Binch (Exc)	Public Member, 4 th District	William Koenig, MD	Med. Dir., EMS Agency
<input checked="" type="checkbox"/> Erick H. Cheung, M.D.	So. CA Psychiatric Society	Kay Fruhwirth	Asst. Dir., EMS Agency
Gerald B. Clute (Exc)	HASC	Richard Tadeo	Asst. Dir., EMS Agency
<input checked="" type="checkbox"/> Robert Flashman, M.D.	L.A. County Medical Assn	Chris Clare	Staff, EMS Agency
VACANT	Public Member, 3 rd District	Roel Amara	"
<input checked="" type="checkbox"/> Clayton Kazan, M.D.	CAL/ACEP	David Wells	"
<input checked="" type="checkbox"/> Ray Mosack	CA State Firefighters' Assn.		
<input checked="" type="checkbox"/> Daryl Parrish	League of California Cities		
Andres Ramirez (Exc)	Peace Officers Assn. of LAC		
<input checked="" type="checkbox"/> Nerses Sanossian, M.D.	American Heart Assn.		
<input checked="" type="checkbox"/> Carole Snyder	Emergency Nurses Assn.		
Jon Thompson	LA Chapter/Fire Chiefs Assn		
Areti Tillou, M.D. (Exc)	L.A. Surgical Society		
<input checked="" type="checkbox"/> Gary Washburn	Public Member, 5 th District		
<input checked="" type="checkbox"/> Bernard Weintraub	S. CA Public Health Assn.		

GUESTS

Samantha Verga-Gates	APCC-LA County & LBMMC	Brett Rosen, MD	LAC-EMS Agency
Mike Sargent	Long Beach Fire Dept.	Dipesh Patel, MD	"
Brian Hudson	Torrance Fire Dept.	Michael Murrey	Montebello Fire Dept.
Richard Roman	Compton Fire Dept.	Dwayne Preston	Long Beach Fire Dept.

(Ab) = Absent; (Exc) = Excused Absence

CALL TO ORDER:

The Emergency Medical Services Commission (EMSC) meeting was held in the EMS Commission Hearing Room, 10100 Pioneer Blvd, Santa Fe Springs, 90670. The meeting was called to order at 1:11 PM by Chairman, Raymond Mosack. A quorum was declared.

INTRODUCTIONS/ANNOUNCEMENTS:

- Dr. William Koenig, Medical Director, EMS Agency, introduced two new EMS Fellows, Dr. Brett Rosen and Dr. Dipesh Patel.
- Chairman Mosack announced the resignation of Commissioner Ron Hansen which was effective June 30, 2014.

CONSENT CALENDAR:

Chairman Mosack called for approval of the Consent Calendar.

M/S/C: Commissioner Austin/Snyder to approve the Consent Calendar.

5. BUSINESS (Old Business)

5.1 Community Paramedicine

Cathy Chidester, Director, EMS Agency, reported that the Office of Statewide Health Planning and Development (OSHPD) will hold a public hearing on Community Paramedicine (HWPP #173) on July 30, 2014 at the Office of Statewide Health Planning and Development in Sacramento. Ms. Chidester and Mr. John Telmos from the EMS Agency will attend to provide testimony.

5.2 1 + 1 Paramedic Staffing Model

Chief Mike Seargent from Long Beach Fire Department presented a data report and provided a status report on the two –year RMD pilot project currently in effect in the City of Long Beach. All 11 paramedic assessment units (PAU) consist of one paramedic and one EMT. For each response, a PAU and engine company is dispatched for a total of 6 personnel which includes two paramedics.

Chief Seargent reported that the project had been in effect for six days and there were 705 responses recorded between July 10, 2014 and July 15, 2014. A report of the run data with type of responses and number of incidents was issued to the Commission for review.

5.3 Wall Time *(Nothing to report)*

5.4 Active Shooter

Ms Chidester reported that the State EMS Authority held a meeting on July 15 at the Los Angeles City Fire Training Center on Active Shooter. The state's model for tactical EMS will continue to be used pending approval by POLST and the State. The Committee is also working on development an active shooter curriculum that will be acceptable by law and EMS.

BUSINESS (New Business)

5.5 Psychiatric Emergency Patients

Chairman Mosack welcomed Dr. Roderick Shaner, Medical Director of the Department of Mental Health (DMH) who was on hand to speak on his Department's management of psychiatric emergency patients in Los

Angeles County. At the May 21, 2014 EMS Commission meeting, it was requested that a representative of the Department of Mental Health provide an update regarding mental health funding in Los Angeles County, prehospital mental health, length of time that mental health patients are detained in hospital emergency departments, hospital bed capacity for mental health patients, and pediatric mental health emergencies.

Dr. Shaner discussed options and emergency department alternatives for psychiatric patients. Three particular area of discussion were:

- SB82, the Mental Health Wellness Act, which he stated was a grant process of \$55M to build an infrastructure for crisis services for mental health patients
- Current and estimated mental health inpatient bed capacity in the County
- Current changes in the Welfare & Institutions' 5150 code.

5.6 Requests for Proposal (RFP) for Emergency Ambulance Transportation

Ms. Chidester reported that the EMS Agency has started work on the draft RFP for emergency ambulance transportation. All contracts will expire in 2016. The general concepts of the RFP must be approved by the EMS Commission and then the State. This information will be provided to the EMS Commission in September.

6. COMMISSIONERS' COMMENTS/REQUESTS

(none)

7. LEGISLATION

(No update)

8. EMS DIRECTOR'S REPORT

- Ms. Chidester reported that there were 7,000 people who were CPR trained on June 5, 2014, Sidewalk CPR Day. There were 90 sites established in L.A. County. In conjunction with four other counties in the State, over 17,000 people were trained that day.
- Ms. Chidester announced that Dr. John Celentano will retire with 38 years of service from L.A. County at the end of July. EMS will hold a celebration in his honor on July 29.
- Dr. William Koenig reported that EMS is in the process of developing a task force on cardiovascular intervention in the field.

9. ADJOURNMENT

The Meeting was adjourned by Chairman Mosack at 2:18 PM. The next meeting will be held on September 17, 2014.

Next Meeting: Wednesday, September 17, 2014
EMS Agency
10100 Pioneer Blvd.
Santa Fe Springs, CA 90670

Recorded by:
Marilyn E. Rideaux
Commission Liaison

LOS ANGELES COUNTY - EMERGENCY MEDICAL SERVICES COMMISSION

Public Hearing

Physician Services for Indigents Program (PSIP) – Proposed Reimbursement Rate Increase for Services Provided in FY 2014-15

September 17, 2014

Kay Fruhwirth, EMS Assistant Director, provided a brief history of the PSIP program. Over the past four or five years the funding for indigent patients services has declined. The big decline was in FY 2008-09 when the EMSA Fund was deleted from the Governor's budget so that funding was lost through the State. The program is a combination of funding primarily through the Maddy Fund (SB 612), SB 1773 and some Measure B and Impacted Hospital Program funding. Back in 2012 there was a significant shortfall in funding the PSIP and the reimbursement rate declined to nine-percent of the Official County Fee Schedule (OCFS). At that time the County had to reduce the reimbursement rate to ensure that the available funding would cover the increasing number of physicians enrolled in the program and increasing number of claims being submitted against the decreasing funding. This was done to ensure that adequate funding was available to cover the projected increase in claims. The actual payment of Fiscal Year (FY) 2012-13 claims was not as high as estimated and resulted in a surplus. Based on this experience and the projection that there will be a surplus for FY 2013-14, DHS wanted to reduce the potential of having a surplus for FY 2014-15, and proposed increasing the reimbursement rate for FY 2014-15.

The proposal before you today is to increase the FY 2014-15 reimbursement rate to 10.5% of the OCFS. Johnny Wong from DHS Fiscal Services is attending today's meeting to provide an overview of the PSIP financial performance and the information that went into determining the reimbursement rate increase for FY 2014-15. A summary of the financial performance was distributed.

Johnny Wong, of DHS Fiscal Services, presented the financial overview of PSIP. Current payment of FY 2013-14 PSIP claims are based upon the 9% of the OCFS reimbursement rate. We are using the actual number of claims paid for FY 2012-13 to forecast the payment of claims for FY(s) 2013-14 and 2014-15, and show a small decrease in claims for 2014-15. One of the major factors in causing a decrease in the number of claims is the implementation of the Affordable Care Act (ACA), which took effect on January 1, 2014. Unfortunately, because of claims processing time lags, ranging from four months to seven months from service date, we do not have a clear picture on how the ACA has impacted the number of claims that will be submitted for FY 2014-15. The numbers are only an estimate. We do know that ACA is having some effect on the number of claims paid under PSIP in LA County. To forecast the reimbursement rate for 2014-15, a few months ago, we looked at the national data on the impact of the ACA on uninsured rates and found that uninsured rates declined about 2.5%. We also looked at our uninsured patients, who were currently being billed to the PSIP, to see if we could project what percentage of this population would qualify for Medi-Cal. We found that about 40% of the PSIP patient population did not have a valid social security number and therefore would not qualify for expanded Medi-Cal coverage under ACA.

After the overview of the program and the financial projection, the hearing was opened for public comment and questions.

Commissioner Binch

Q. Who did you coordinate with on your estimation of number of 2014-15 claims?

A. We reviewed and analyzed our in-house claims data provided by AIA (our claims adjudicator), looked at the year-to-date and month-to-month trends, reviewed publications on the impact of the ACA on uninsured rates, and consulted with EMS.

Q. Did you use any independent experts to look at the preliminary numbers?

A. No, other than what was published.

Q. What's the contingency plan if the number of claims is substantially lower than forecasted? Will you be able to reach back and increase or decrease the compensation based on the actual forecast?

A. Each year the funds allocated to the program must be distributed in that year. When there is a surplus at the end of the year, a raise-up is done and the balance is distributed proportionally, as required by law, based on all paid claims processed during that year. DHS is trying to be conservative in its estimate to avoid running out of funds that would warrant any decrease in the reimbursement rate during the year.

General comment made by Commissioner Binch:

I am concerned about the very small amount of the forecast of the proposed rate increase considering we were able to catch up the deficit from previous year and financing this year. With that deficit financed and the Affordable Care Act's impact on the number of claims, I would have hoped to see a higher percentage and if at all possible in any way reconcile that, and compensate all claims based on later revisions.

Commissioner Tillou

Q. When do you anticipate that DHS will start reimbursing at the 2014-15 rate?

A. October 2014, bills will be accepted for the 2014-15 rate.

Q. Do you know what the 2013-14 surplus rate is at this time?

A. No, because we are still paying 2013-14 claims. Currently, we anticipate a \$2 million surplus.

Commissioner Flashman

- Q. Will the pay-out be expedited? A six to seven month payout is not timely.
- A. If we get a clean claim it is paid right away (within 20 working days). If there is a problem with the claim or it is incomplete, it is denied and this process can extend the payment period.
- Q. What is the average amount of time it takes for claims to be paid?
- A. Kay Fruhwirth indicated that she did not have the exact time but will ask AIA to provide the information on claims processing and will provide this back to the EMSC.

Jamie Garcia, Vice President, Hospital Association of Southern California thanked the EMSC for holding a public hearing on PSIP. He remarked that this was a turning point in a positive direction as we are discussing an increase instead of a decrease in physician reimbursement.

There were no other comments from the audience on PSIP.

PHYSICIAN SERVICES FOR INDIGENT PROGRAM CLAIMS PROCESSING TIME LINE

ER CLAIM

Physician: **90 calendar days** from patient discharge for collection efforts prior to submission of claim

AIA: **20 working days** from receipt of claim to either approve or deny claim

Appeal: Physician has **30 days** to re-submit any denied claim with a maximum of two (2) appeals. If provider is not satisfied with the decision, claim is reviewed by the Physician Reimbursement Advisory Committee (PRAC) for final resolution, which requires adding an additional **20 working days for each cycle** for AIA to process Appeals (paid/denied).

IMPACTED HOSPITAL PROGRAM (IHP)

Same as ER Claim, however; AIA's **20 working days** process time is counted from the date of IHP patient data match (i.e., patient and service date data are matched between hospital claim and physician claim). Since IHP hospitals is given an extended period (between 90 days to 180 days from patient discharge) to submit the claim, the processing time line for IHP claims can range from 150 to 240 calendar days, not including appeals.

OTHER FACTORS

Many other factors are involved that could extend the time from claim submission to payment, which include whether the provider is already enrolled in PSIP or still needs to enroll, claim submission issues, and what specific program (ER, Trauma or IHP) is being billed.



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

**Los Angeles County
Board of Supervisors**

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd., Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate, and quality
emergency and disaster
medical services*



Health Services
<http://ems.dhs.lacounty.gov/>

CORRESPONDENCE 2.1

October 27, 2014

Ralph Mundell, Fire Chief
Beverly Hills Fire Department
445 N. Rexford Drive
Beverly Hills, CA 90210

Dear Chief Mundell,

This is to inform you that Beverly Hills Fire Department (BH) has been approved by the Los Angeles County Emergency Medical Services (EMS) Agency for the utilization of QuikClot® Combat Gauze™ in patients with traumatic hemorrhage not amenable to tourniquet and other methods of external hemorrhage control.

The quality improvement process required for implementation and tracking the utilization of hemostatic dressings will be reviewed during your annual Program Review or as deemed necessary by the EMS Agency. Additionally, BH may be required to submit data to the EMS Agency for purposes of evaluating and aggregate reporting on the use of hemostatic dressings in our system.

Thank you for your valuable service and ongoing commitment to EMS. Please contact me at 562 347-1600 or Susan Mori at 562 347-1609 for any question or concerns.

Very truly yours,

William Koenig, MD
Medical Director

WK:sm
10-27

c: Director, EMS Agency
Assistant Director, EMS Agency
Medical Director, BH
EMS Director, BH
Paramedic Coordinator, BH
Nurse Educator, BH

CORRESPONDENCE 2.2



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd., Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate, and quality
emergency and disaster
medical services*



Health Services
<http://ems.dhs.lacounty.gov/>

October 27, 2014

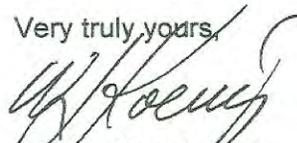
Ralph Terrazas, Fire Chief
Los Angeles Fire Department
200 N. Main Street
Los Angeles, CA 90012

Dear Chief Terrazas:

This is to inform you that Los Angeles Fire Department (CI) has been approved by the Los Angeles County Emergency Medical Services (EMS) Agency for the utilization of QuikClot® Combat Gauze™ in patients with traumatic hemorrhage not amenable to tourniquet and other methods of external hemorrhage control.

The quality improvement process required for implementation and tracking the utilization of hemostatic dressings will be reviewed during your annual Program Review or as deemed necessary by the EMS Agency. Additionally, CI may be required to submit data to the EMS Agency for purposes of evaluating and aggregate reporting on the use of hemostatic dressings in our system.

Thank you for your valuable service and ongoing commitment to EMS. Please contact me at (562) 347-1600 or Susan Mori at (562) 347-1609 for any questions or concerns.

Very truly yours,

William Koenig, MD
Medical Director

WK:sm
10-27

c: Director, EMS Agency
Assistant Director, EMS Agency
Medical Director, CI
Assistant Chief, EMS Director, CI
Battalion Chief, Paramedic Coordinator, CI
CE Program Director, CI

CORRESPONDENCE 2.3

October 23, 2014

Cathy Chidester
EMS Commission
LA County Department of Health Services
10100 Pioneer Blvd. Ste 200
Santa Fe Springs, CA 90670

Cathy,

Please accept this letter as notice of my resignation as Los Angeles EMS Commissioner, representing the Hospital Association of Southern California. As I no longer work as a CEO of a hospital organization, it is my understanding that I do not qualify for holding this office.

It has been my honor to serve as Commissioner working with very committed Commissioners for the county. I am proud to have served with these talented leaders. It is because of their hard work and dedication that EMS continues to provide much needed care to this county.

I am especially grateful to you for your continued leadership and dedication.

Sincerely,

A handwritten signature in cursive script, appearing to read "Gerald Clute".

Gerald Clute
Commissioner

cc
Jaime Garcia
Hospital Association of Southern California
Regional Vice President, Greater LA Area
515 South Figueroa St, STE 1300
Los Angeles, CA 90071



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

CORRESPONDENCE 2.4

October 20, 2014

**Los Angeles County
Board of Supervisors**

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate, and quality
emergency and disaster
medical services.*

Harold Scoggins, Fire Chief
Glendale Fire Department
421 Oak Street
Glendale, California 91204

Dear Chief Scoggins:

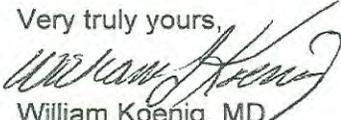
RE: NEWLY APPOINTED MEDICAL DIRECTOR

This letter is to acknowledge that the Emergency Medical Services (EMS) Agency has received notification from Glendale Fire Department (GL) that effective August 1, 2014, Angelica Loza-Gomez, M.D., has been appointed as Medical Director and will be providing medical oversight to GL's paramedic program.

Based on the documents provided to the EMS Agency, Dr. Gomez meets the requirements as Medical Director set forth in the Los Angeles County Prehospital Care Manual, Reference No. 411, Provider Agency Medical Director.

The EMS Agency has also received the necessary documentation confirming that Dr. Gomez has agreed to purchase drugs and medical supplies for GL and will be providing complete oversight to GL's controlled substance program.

I would like to welcome Dr. Gomez to the Los Angeles County EMS system. If there are any questions during this transition or in the future, please don't hesitate to contact me directly.

Very truly yours,

William Koenig, MD
Medical Director

WK:gw
10-13

- c. Medical Director, Glendale Fire Department
EMS Director, Glendale Fire Department
Paramedic Coordinator, Glendale Fire Department
Nurse Educator, Glendale Fire Department



Health Services
<http://ems.dhs.lacounty.gov>



EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To improve health
through leadership,
service and education*

October 8, 2014

Doug Cain, Executive Vice President
Antelope Ambulance Service
P.O. Box 5480
Lancaster, CA 93539-5480

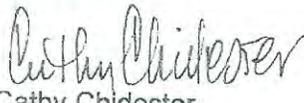
Dear Mr. Cain:

This is in response to your letter dated July 8, 2014 requesting consideration by the Emergency Medical Services (EMS) Agency to split an existing Exclusive Operating Area (EOA) for the 2016 Emergency Ambulance Transportation Agreements.

As discussed during our telephone conversation, the EMS Agency is in the process of drafting the Request for Proposal (RFP) for the 2016 Emergency Ambulance Transportation Agreements. All information related to this process and the draft proposal are confidential. It would be inappropriate and potentially jeopardize the integrity of the RFP if the EMS Agency entered into discussions or accepted changes from an individual private ambulance company (and potential bidder) regarding the design of the EOAs and/or the RFP.

Your letter and suggestion has been reviewed by the EMS Agency. Thank you for your continued support of the Los Angeles County EMS system.

Very truly yours,


Cathy Chidester
Director

c: Fifth District, Health Deputy
Fifth District, Field Deputy
Deputy Director, DHS



Health Services
<http://ems.dhs.lacounty.gov>



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

**Los Angeles County
Board of Supervisors**

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate, and quality
emergency and disaster
medical services.*



Health Services
<http://ems.dhs.lacounty.gov>

CORRESPONDENCE 2.6

October 6, 2014

Dan Castillo
Chief Executive Officer
LAC+USC Medical Center
1200 N. State Street
Los Angeles, CA 90033

Dear Mr. Castillo:

ALLOCATION OF SENATE BILL 1773 PEDIATRIC TRAUMA CENTER FUNDING (RICHIE'S FUND) FOR FISCAL YEAR 2013-2014

We are in receipt of LAC+USC Medical Center's (USC) proposal, in response to the Emergency Medical Services (EMS) Agency's letter dated January 15, 2014, to expand services in centers currently designated as Pediatric Trauma Centers (PTC). Based on the quality and content of the proposal, in combination with USC's pediatric trauma volume, we are pleased to inform you that a journal voucher for USC's allocation of Senate Bill (SB) 1773, PTC funding (Richie's Fund), for Fiscal Year 2013-2014 was approved on September 30, 2014, in the amount of **\$312,931.31** (JVCT-HS-CSFH1503-6) and will be transferred directly to your facility by the Auditor Controller's Office.

As stated in Exhibit B.1 of the Trauma Center Service Agreement, "Within six (6) months of receipt of these funds, the Pediatric Trauma Centers shall submit documentation for review and approval by the Department of Health Services' Emergency Medical Services (EMS) Agency to substantiate appropriate use for expenditures to augment pediatric services in accordance with the Legislation's requirements." Please ensure that the funds are utilized in a manner included in the proposal submitted.

If you have any questions or need additional information, please contact Christy Preston, Trauma System Program Manager, at (562) 347-1660, or Kay Fruhwirth, Assistant Director, at (562) 347-1596.

Very truly yours,


Cathy Chidester
Director

CC:CP:cp

c: Director, Department of Health Services
Chief Deputy Director, Department of Health Services
Expenditure Management, Department of Health Services
Hospital Association of Southern California
Trauma Director, LAC+USC Medical Center
Trauma Program Manager, LAC+USC Medical Center
Trauma Hospital Advisory Committee



EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

CORRESPONDENCE 2.7

October 6, 2014

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate, and quality
emergency and disaster
medical services.*

Thomas M. Priselac
President/CEO
Cedars-Sinai Medical Center
8700 Beverly Boulevard
Los Angeles, CA 90048

Dear Mr. Priselac:

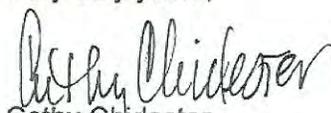
ALLOCATION OF SENATE BILL 1773 PEDIATRIC TRAUMA CENTER FUNDING (RICHIE'S FUND) FOR FISCAL YEAR 2013-2014

We are in receipt of Cedars-Sinai Medical Center's (CSM) proposal, in response to the Emergency Medical Services (EMS) Agency's letter dated January 15, 2014, to expand services in centers currently designated as Pediatric Trauma Centers (PTC). Based on the quality and content of the proposal, in combination with CSM's pediatric trauma volume, we are pleased to inform you that a warrant for CSM's allocation of Senate Bill (SB) 1773, PTC funding (Richie's Fund), for Fiscal Year 2013-2014 was issued on September 30, 2014, in the amount of **\$19,526.10** (No. TS0020859435) and mailed directly to your facility by the Auditor Controller's Office.

As stated in Exhibit B.1 of the Trauma Center Service Agreement, "Within six (6) months of receipt of these funds, the Pediatric Trauma Centers shall submit documentation for review and approval by the Department of Health Services' Emergency Medical Services (EMS) Agency to substantiate appropriate use for expenditures to augment pediatric services in accordance with the Legislation's requirements." Please ensure that the funds are utilized in a manner included in the proposal submitted.

If you have any questions or need additional information, please contact Christy Preston, Trauma System Program Manager, at (562) 347-1660, or Kay Fruhwirth, Assistant Director, at (562) 347-1596.

Very truly yours,


Cathy Chidester
Director

CC:CP:cp

- c: Director, Department of Health Services
- Chief Deputy Director, Department of Health Services
- Expenditure Management, Department of Health Services
- Hospital Association of Southern California
- Trauma Director, Cedars-Sinai Medical Center
- Trauma Program Manager, Cedars-Sinai Medical Center
- Trauma Hospital Advisory Committee



Health Services
<http://ems.dhs.lacounty.gov>



EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

To ensure timely, compassionate, and quality emergency and disaster medical services.

October 6, 2014

Delvecchio Finley
Chief Executive Officer
Harbor/UCLA Medical Center
1000 W. Carson Street
Torrance, CA 90502

Dear Mr. Finley:

ALLOCATION OF SENATE BILL 1773 PEDIATRIC TRAUMA CENTER FUNDING (RICHIE'S FUND) FOR FISCAL YEAR 2013-2014

We are in receipt of Harbor/UCLA Medical Center's (HGH) proposal, in response to the Emergency Medical Services (EMS) Agency's letter dated January 15, 2014, to expand services in centers currently designated as Pediatric Trauma Centers (PTC). Based on the quality and content of the proposal, in combination with HGH's pediatric trauma volume, we are pleased to inform you that a journal voucher for HGH's allocation of Senate Bill (SB) 1773, PTC funding (Richie's Fund), for Fiscal Year 2013-2014 was approved on September 30, 2014, in the amount of **\$241,506.92** (JVCT-HS-CSFH1503-6) and will be transferred directly to your facility by the Auditor Controller's Office.

As stated in Exhibit B.1 of the Trauma Center Service Agreement, "Within six (6) months of receipt of these funds, the Pediatric Trauma Centers shall submit documentation for review and approval by the Department of Health Services' Emergency Medical Services (EMS) Agency to substantiate appropriate use for expenditures to augment pediatric services in accordance with the Legislation's requirements." Please ensure that the funds are utilized in a manner included in the proposal submitted.

If you have any questions or need additional information, please contact Christy Preston, Trauma System Program Manager, at (562) 347-1660, or Kay Fruhwirth, Assistant Director, at (562) 347-1596.

Very truly yours,

Cathy Chidester
Director

CC:CP:cp

- c: Director, Department of Health Services
- Chief Deputy Director, Department of Health Services
- Expenditure Management, Department of Health Services
- Hospital Association of Southern California
- Trauma Director, Harbor/UCLA Medical Center
- Trauma Program Manager, Harbor/UCLA Medical Center
- Trauma Hospital Advisory Committee

Health Services
<http://ems.dhs.lacounty.gov>





**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

CORRESPONDENCE 2.9

October 6, 2014

**Los Angeles County
Board of Supervisors**

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate, and quality
emergency and disaster
medical services.*

Diana Hendel
Chief Executive Officer
Long Beach Memorial Medical Center
2801 Atlantic Avenue
Long Beach, CA 90806

Dear Ms. Hendel:

**ALLOCATION OF SENATE BILL 1773 PEDIATRIC TRAUMA CENTER
FUNDING (RICHIE'S FUND) FOR FISCAL YEAR 2013-2014**

We are in receipt of Long Beach Memorial Medical Center's (LBM) proposal, in response to the Emergency Medical Services (EMS) Agency's letter dated January 15, 2014, to expand services in centers currently designated as Pediatric Trauma Centers (PTC). Based on the quality and content of the proposal, in combination with LBM's pediatric trauma volume, we are pleased to inform you that a warrant for LBM's allocation of Senate Bill (SB) 1773, PTC funding (Richie's Fund), for Fiscal Year 2013-2014 was issued on September 30, 2014, in the amount of **\$101,227.37** (No. TS0020859436) and mailed directly to your facility by the Auditor Controller's Office.

As stated in Exhibit B.1 of the Trauma Center Service Agreement, "Within six (6) months of receipt of these funds, the Pediatric Trauma Centers shall submit documentation for review and approval by the Department of Health Services' Emergency Medical Services (EMS) Agency to substantiate appropriate use for expenditures to augment pediatric services in accordance with the Legislation's requirements." Please ensure that the funds are utilized in a manner included in the proposal submitted.

If you have any questions or need additional information, please contact Christy Preston, Trauma System Program Manager, at (562) 347-1660, or Kay Fruhwirth, Assistant Director, at (562) 347-1596.

Very truly yours,

Cathy Chidester
Director

CC:CP:cp

- c: Director, Department of Health Services
- Chief Deputy Director, Department of Health Services
- Expenditure Management, Department of Health Services
- Hospital Association of Southern California
- Trauma Director, Long Beach Memorial Medical Center
- Trauma Program Manager, Long Beach Memorial Medical Center
- Trauma Hospital Advisory Committee



Health Services
<http://ems.dhs.lacounty.gov>



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

**Los Angeles County
Board of Supervisors**

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate, and quality
emergency and disaster
medical services.*



Health Services
<http://ems.dhs.lacounty.gov>

CORRESPONDENCE 2.10

October 6, 2014

Saliba Salo
President
Northridge Hospital Medical Center
18300 Roscoe Blvd.
Northridge, CA 91328

Dear Mr. Salo:

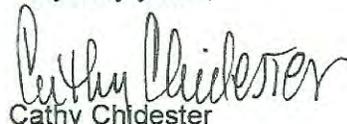
ALLOCATION OF SENATE BILL 1773 PEDIATRIC TRAUMA CENTER FUNDING (RICHIE'S FUND) FOR FISCAL YEAR 2013-2014

We are in receipt of Northridge Hospital Medical Center's (NRH) proposal, in response to the Emergency Medical Services (EMS) Agency's letter dated January 15, 2014, to expand services in centers currently designated as Pediatric Trauma Centers (PTC). Based on the quality and content of the proposal, in combination with NRH's pediatric trauma volume, we are pleased to inform you that a warrant for NRH's allocation of Senate Bill (SB) 1773, PTC funding (Richie's Fund), for Fiscal Year 2013-2014 was issued on September 30, 2014, in the amount of **\$1,000,000.00** (No.TS0020859437) and mailed directly to your facility by the Auditor Controller's Office.

As stated in Exhibit B.1 of the Trauma Center Service Agreement, "Within six (6) months of receipt of these funds, the Pediatric Trauma Centers shall submit documentation for review and approval by the Department of Health Services' Emergency Medical Services (EMS) Agency to substantiate appropriate use for expenditures to augment pediatric services in accordance with the Legislation's requirements." Please ensure that the funds are utilized in a manner included in the proposal submitted.

If you have any questions or need additional information, please contact Christy Preston, Trauma System Program Manager, at (562) 347-1660, or Kay Fruhwirth, Assistant Director, at (562) 347-1596.

Very truly yours,


Cathy Chidester
Director

CC:CP:cp

c: Director, Department of Health Services
Chief Deputy Director, Department of Health Services
Expenditure Management, Department of Health Services
Hospital Association of Southern California
Trauma Director, Northridge Hospital Medical Center
Trauma Program Manager, Northridge Hospital Medical Center
Trauma Hospital Advisory Committee



EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate, and quality
emergency and disaster
medical services.*

October 6, 2014

Richard D. Cordova
President/CEO
Children's Hospital Los Angeles
4650 W. Sunset Blvd.
Los Angeles, CA 90027

Dear Mr. Cordova:

ALLOCATION OF SENATE BILL 1773 PEDIATRIC TRAUMA CENTER FUNDING (RICHIE'S FUND) FOR FISCAL YEAR 2013-2014

We are in receipt of Children's Hospital Los Angeles' (CHH) proposal, in response to the Emergency Medical Services (EMS) Agency's letter dated January 15, 2014, to expand services in centers currently designated as Pediatric Trauma Centers (PTC). Based on the quality and content of the proposal, in combination with CHH's pediatric trauma volume, we are pleased to inform you that a warrant for CHH's allocation of Senate Bill (SB) 1773, PTC funding (Richie's Fund), for Fiscal Year 2013-2014 was issued on October 1, 2014, in the amount of **\$193,205.54** (No.TS0020865754) and mailed directly to your facility by the Auditor Controller's Office.

As stated in Exhibit B.1 of the Trauma Center Service Agreement, "Within six (6) months of receipt of these funds, the Pediatric Trauma Centers shall submit documentation for review and approval by the Department of Health Services' Emergency Medical Services (EMS) Agency to substantiate appropriate use for expenditures to augment pediatric services in accordance with the Legislation's requirements." Please ensure that the funds are utilized in a manner included in the proposal submitted.

If you have any questions or need additional information, please contact Christy Preston, Trauma System Program Manager, at (562) 347-1660, or Kay Fruhwirth, Assistant Director, at (562) 347-1596.

Very truly yours,

Cathy Chidester
Director

CC:CP:cp

- c: Director, Department of Health Services
- Chief Deputy Director, Department of Health Services
- Expenditure Management, Department of Health Services
- Hospital Association of Southern California
- Trauma Director, Children's Hospital Los Angeles
- Trauma Program Manager, Children's Hospital Los Angeles
- Trauma Hospital Advisory Committee

Health Services
<http://ems.dhs.lacounty.gov>





**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

October 6, 2014

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate, and quality
emergency and disaster
medical services.*

Shannon O'Kelley
Chief Operating Officer
UCLA Medical Center
757 Westwood Plaza
Los Angeles, CA 90095

Dear Mr. O'Kelley:

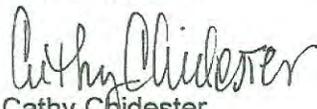
**ALLOCATION OF SENATE BILL 1773 PEDIATRIC TRAUMA CENTER
FUNDING (RICHIE'S FUND) FOR FISCAL YEAR 2013-2014**

We are in receipt of UCLA Medical Center's (UCLA) proposal, in response to the Emergency Medical Services (EMS) Agency's letter dated January 15, 2014, to expand services in centers currently designated as Pediatric Trauma Centers (PTC). Based on the quality and content of the proposal, in combination with UCLA's pediatric trauma volume, we are pleased to inform you that a warrant for UCLA's allocation of Senate Bill (SB) 1773, PTC funding (Richie's Fund), for Fiscal Year 2013-2014 was issued on September 30, 2014, in the amount of **\$20,553.78** (No. TS0020859434) and mailed directly to your facility by the Auditor Controller's Office.

As stated in Exhibit B.1 of the Trauma Center Service Agreement, "Within six (6) months of receipt of these funds, the Pediatric Trauma Centers shall submit documentation for review and approval by the Department of Health Services' Emergency Medical Services (EMS) Agency to substantiate appropriate use for expenditures to augment pediatric services in accordance with the Legislation's requirements." Please ensure that the funds are utilized in a manner included in the proposal submitted.

If you have any questions or need additional information, please contact Christy Preston, Trauma System Program Manager, at (562) 347-1660, or Kay Fruhwirth, Assistant Director, at (562) 347-1596.

Very truly yours,


Cathy Chidester
Director

CC:CP:cp

- c: Director, Department of Health Services
- Chief Deputy Director, Department of Health Services
- Expenditure Management, Department of Health Services
- Hospital Association of Southern California
- Trauma Director, UCLA Medical Center
- Trauma Program Manager, UCLA Medical Center
- Trauma Hospital Advisory Committee



Health Services
<http://ems.dhs.lacounty.gov>



EMERGENCY MEDICAL
SERVICES AGENCY
LOS ANGELES COUNTY

CORRESPONDENCE 2.13

October 6, 2014

**Los Angeles County
Board of Supervisors**

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

TO: Medical Director, Each Public and Private Provider Agencies
CEO, Each Private Provider Agency
Fire Chief, Each Public Provider Agency
EMS Coordinator, Each Public and Private
Provider Agencies
Nurse Educators, Each Public and Private
Provider Agencies
Emergency Department Director, Each 9-1-1 Receiving Facility
Paramedic Care Coordinator, Each Base Hospital

FROM: William Koenig, M.D., Medical Director 

SUBJECT: UPDATE ON EBOLA VIRUS DISEASE (EVD) FOR EMS

Cathy Chidester
Director

William Koenig, MD
Medical Director

The Emergency Medical (EMS) Agency is working closely with Los Angeles Department of Public Health (LACDPH) to monitor the current status of EVD. The intent of this notice is to provide guidance for the identification of patients with suspected EVD, and if identified, appropriate management in the pre-hospital setting. Since many of the standard precautions already in place will remain unchanged, this update will emphasize changes in standard procedure. More detailed discussions are accessible at the LACDPH, Centers for Disease Control (CDC), and State of California EMS Authority websites listed below.

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate, and
quality emergency and
disaster medical
services.*

To date, there have been four (4) people in Los Angeles County reported to LACDPH that met travel criteria (see attached EMS assessment guideline); however, none met clinical criteria for Ebola testing. There are no confirmed cases of Ebola in Los Angeles County. Given the low risk of EVD in Los Angeles, and that it may be impractical to further question callers with common nonspecific symptoms, the EMS Agency currently is not recommending call takers at Public Safety Answering Points (PSAPs) or dispatch centers screen callers for risk factors of EVD.

Therefore the attached guideline is focused towards the pre-hospital basic and advanced life support providers:

DETECT: Assess the patient for signs and symptoms related to EVD infection and verify travel history.

PROTECT: Use good infection control practices:

Standard, contact, and droplet precautions are sufficient for most situations when treating a patient with suspected EVD. This would include the following:

- Gloves
- Gown (fluid resistant or impermeable)
- Eye protection (goggles, or face shield that fully covers the front and sides of the face)



Health Services
<http://ems.dhs.lacounty.gov>

- Surgical mask (N-95 masks are recommended for aerosolizing procedures such as intubation, open suction, or CPR)
- Additional PPE such as double gloving, disposable shoe and leg coverings are recommended when performing resuscitation procedures or presence of copious bodily fluids from the patient

Practice frequent and proper hand washing techniques.

Equipment and unit decontamination should be done using standard cleaning precautions already in place. EMS provider agencies should consider removing the vehicle from service until disinfection can be accomplished.

If you are concerned that you have been exposed to or came into contact with a suspected EVD case, contact your local public health department immediately for further directions.

- Los Angeles County Department of Public Health (213) 240-7941
- Long Beach Health Department (562) 435-6711
- Pasadena Health Department (626) 744-6043

RESPOND: Implement an EVD response plan using the EMS guidance document and other guidelines from resources listed below.

Patient destination policies have not been changed but *EMS personnel should notify the receiving facility immediately* so the hospital can make the appropriate preparations to receive the patient.

If you or your staff has any questions, please contact Dr. Koenig at (562) 347-1600 or Roel Amara at (562) 347-1602. During after hours, please contact the Medical Alert Center at (562) 347-1703.

Additional information and resources at the following websites:

<http://publichealth.lacounty.gov/acd/diseases/Ebola.htm>

http://www.emsa.ca.gov/ebola_control

<http://cdph.ca.gov/programs/cder/Pages/Ebola.aspx>

<http://www.bt.cdc.gov/han/han00364.asp>

<http://www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html>

WK:jr
10-05

Enclosure



Ebola Virus Disease (EVD) Patient Assessment Criteria for EMS Personnel

EMS patient assessment criteria for transport precautions and hospital notification are:

1. Fever, headache, joint and muscle aches, weakness, fatigue, diarrhea, vomiting, stomach pain and lack of appetite, and in some cases, bleeding.
2. Travel to West Africa* within 21 days (3 weeks) of symptom onset.

AND

If both criteria are met, including the time component of criteria 2, the patient should be transported to the most accessible receiving (MAR) facility and STANDARD, CONTACT, and DROPLET precautions followed during further assessment and treatment**

IMMEDIATELY Notify the Receiving Facility of Suspected Ebola Case(s)

If patient is not transported (refusal, pronouncement, etc.):

Inform Local Public Health Authorities: Los Angeles County Public Health Department (213) 240-7941
Long Beach Health Department (562) 435-6711
Pasadena Health Department (626) 744-6043

*Affected West African countries as of October 6, 2014: Guinea, Liberia, and Sierra Leone. Refer to CDC website for updated list of affected countries: <http://www.cdc.gov/vhf/ebola/outbreaks/index.html>

**See EMS Agency Guidance memorandum



EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

CORRESPONDENCE 2.14

Los Angeles County
Board of Supervisors

September 25, 2014

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

TO: Medical Director, Each Private Paramedic Provider Agency
CEO, Each Private Paramedic Provider Agency
Paramedic Coordinator, Each Private Paramedic Provider Agency

FROM: William Koenig, M.D., Medical Director, 

SUBJECT: NORMAL SALINE INTRAVENOUS SOLUTION SHORTAGE

Cathy Chidester
Director

William Koenig, MD
Medical Director

Due to an increase demand for normal saline intravenous solution dating back to the 4th quarter of 2013, pharmaceutical manufacturers are unable to keep up with the demand. Despite their efforts to increase production in addition to the Food and Drug Administration (FDA) approving overseas shipments of normal saline, the shortage continues. In order to address local supply issues, the following actions should be implemented:

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

- Effective immediately, all private paramedic provider agencies are authorized to decrease par levels of 1-L normal saline intravenous solutions on approved Advanced Life Support Units from 10-1L bags to a total of 5-1 L bags.
- Where indicated (e.g. normotensive patients), a normal saline lock should be established in lieu of providing a continuous normal saline drip.

*To ensure timely,
compassionate, and
quality emergency and
disaster medical
services.*

The Emergency Medical Services (EMS) Agency will continue to monitor the situation and update provider agencies as information becomes available.

If you or your staff has any questions, please contact John Telmos, Chief Prehospital Operations at (562) 347-1677.

WK:jt
08-18



Health Services
<http://ems.dhs.lacounty.gov>



EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

CORRESPONDENCE 2.15

Los Angeles County
Board of Supervisors

September 25, 2014

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

TO: Base Hospital Medical Directors
Prehospital Care Coordinators
Paramedic Coordinators

FROM: William Koenig, M.D., Medical Director

SUBJECT: DOPAMINE SHORTAGE/COUNTYWIDE UTILIZATION

Cathy Chidester
Director

William Koenig, MD
Medical Director

At the September 9, 2014 Medical Council Meeting a there was discussion on supply and utilization of Dopamine Hydrochloride injection (Dopamine) by Prehospital providers. Data provided by The Emergency Medical Services "EMS" Agency revealed countywide utilization of 153 cases in calendar year 2013 and similar statistics for the first two quarters of 2014.

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

Medical Council attendees voted to eliminate Dopamine as being a mandatory inventory item on Ref. No. 703, ALS Unit Inventory and Ref. No. 706, ALS EMS Aircraft Inventory. Effective October 1, 2014, Dopamine will be moved to the optional area on reference 703 and 706.

This decision is supported by the sporadic availability of a specific concentration of dopamine being readily available to field providers coupled by low utilization.

*To ensure timely,
compassionate, and
quality emergency and
disaster medical
services.*

Approval to remove Dopamine will be at the discretion of each approved Paramedic Provider Agency Medical Director taking into account the provider agencies geographic area of coverage and transport times. Written notification to the EMS Agency of the provider agencies intent is required prior to removal.

Prehospital Care Coordinators (PCC) should alert their Mobile Intensive Care Nurses (MICN's) and physicians answering the paramedic radio that this drug may not be available to all provider agencies.

If you or your staff has any questions, please contact John Telmos, Chief Prehospital Operations at (562) 347-1677.

WK:jt
09-28



Health Services
<http://ems.dhs.lacounty.gov>

Confidential Quality Improvement information: The information contained in this document is privileged and strictly confidential under State Law, including Evidence Code Section 1157.



EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate and quality
emergency and disaster
medical services.*



Health Services
<http://ems.dhs.lacounty.gov>

CORRESPONDENCE 2.16

TO: Medical Director
All 9-1-1 Receiving Facilities
All 9-1-1 Provider Agencies

FROM: William Koenig, MD
Medical Director

SUBJECT: **SENIOR PHYSICIAN OPENING AT EMERGENCY
MEDICAL SERVICES AGENCY**

The Emergency Medical Services (EMS) Agency currently has an opening for a full-time physician at the level of Senior Physician. This position will report directly to the Medical Director of the EMS Agency and will be responsible for a variety of complex administrative tasks, which include the following:

- System Planning and Quality Assessment
- Research Design
- Data Management and Analysis
- Disaster Operations
- Prehospital Protocol Development
- Medical Oversight

The Senior Physician with an Emergency Medicine specialty has a monthly salary range of \$13,730.00 - \$24,075.00.

The EMS Agency is requesting that you share this information with the members of your medical group. Interested parties should be instructed to submit a letter of interest to Dr. William Koenig at wkoenig@dhs.lacounty.gov and apply for this position by going to the link below and submitting their application.

<https://sjobs.brassring.com/tqwebhost/jobdetails.aspx?partnerid=25082&siteid=5045&jobid=35624>

If you have any question please call me at 562-347-1600.

WK.kf



CORRESPONDENCE 2.17

COUNTY OF LOS ANGELES EMERGENCY MEDICAL SERVICES COMMISSION

10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
(562) 347-1604 FAX (562) 941-5835

Los Angeles County Board of Supervisors

Gloria Molina
First District
Mark Ridley-Thomas
Second District
Zev Yaroslavsky
Third District
Don Knabe
Fourth District
Michael D. Antonovich
Fifth District

Commissioners

Mr. David Austin
LA County Ambulance Association
Chief Robert E. Barnes
Los Angeles County Police Chiefs Assn.
Mr. Frank Binch
Public Member (4th District)
Erick H. Cheung, M.D.
Southern CA Psychiatric Society
Mr. Gerald B. Clute
Hospital Association of Southern CA
Robert Flashman, M.D.
LA County Medical Association
Mr. Ron Hansen
Public Member (3rd District)
Clayton Kazan, M.D.
California Chapter-American College of
Emergency Physicians (CAL-ACEP)
Chief Raymond A. Mosack, Chair
CA State Firefighters' Association
Mr. Daryl Parrish
League of Calif. Cities/LA County Division
Capt. Andres Ramirez
Peace Officers Association of LA County
Nurses Sanossian, MD, FAHA
American Heart Association
Western States Affiliate
Carole A. Snyder, RN, Vice Chair
Emergency Nurses Association
Chief Jon D. Thompson
LA Chapter-Fire Chiefs Association
Areti Tiliou, M.D.
LA Surgical Society
Mr. Gary Washburn
Public Member (5th District)
Mr. Bernard S. Weintraub
Southern California Public Health Assn.
VACANT
Public Member (1st District)
Public Member (2nd District)

Executive Director

Cathy Chidester
Director, EMS Agency
(562) 347-1604
cchidester@dhs.lacounty.gov

Commission Liaison

Marilyn Rideaux
(323) 890-7392
mrideaux@dhs.lacounty.gov

August 14, 2014

TO: Each Supervisor
FROM: Cathy Chidester *CC*
Executive Director

SUBJECT: EMERGENCY MEDICAL SERVICES COMMISSION
ANNUAL REPORT – FY 2013/2014

Attached is the Emergency Medical Services Commission's (EMSC) Report to the Board of Supervisors which is submitted annually in compliance with County Code, Chapter 3.20, Section 3.20.070.5.

The Ordinance provides for nineteen (19) EMSC members. Seventeen (17) of the positions were filled during the reporting period with two (2) vacancies. The vacancies are noted in the attached report. The EMSC continually reviews its' membership structure and the EMS Agency actively recruits to fill vacancies.

The attached report describes the structure, membership and major activities of the Commission and the four standing subcommittees from July 1, 2013 through June 30, 2014. If you should have any questions please feel free to contact me at (562) 347-1604.

CC:mr

Attachment

c: Director, DHS
County Counsel
Executive Officer, Board of Supervisors
EMS Commission
Health Deputies

**ANNUAL REPORT
TO THE
BOARD OF SUPERVISORS**



EMERGENCY MEDICAL SERVICES COMMISSION

FY JULY 1, 2013 – JUNE 30, 2014

INTRODUCTION

The Emergency Medical Services (EMS) Commission was established by the Board of Supervisors in October 1979 under Ordinance No. 12332 of the County Code, Chapter 3.20. The EMSC performs the functions of the Emergency Medical Care Committee as defined in the Health and Safety Code, Section 1797.270, et seq.

The EMS Commission acts in an advisory capacity to the Board of Supervisors and the Director of Health Services regarding County policies, programs, and standards for emergency medical care services, including paramedic services throughout Los Angeles County.

The EMS Commission is composed of 19 members appointed by the Board of Supervisors of which five of them are public members representing each of the County Supervisorial Districts. Each of these 19 members serves a four year term at the pleasure of the Board of Supervisors and may not serve more than two consecutive four-year terms as stipulated in the EMS Commission Bylaws. The Board of Supervisors can authorize a commissioner to serve beyond the two-consecutive terms upon request.

The EMS Commission meetings are held on the third Wednesday of each odd month at 1:00 PM in the EMS Commission Hearing Room, 10100 Pioneer Boulevard, 1st Floor, Santa Fe Springs, CA 90670 and are open to the public. The EMS Agency is conveniently located in the same building on the 2nd Floor.

DUTIES

The Commission shall perform all the functions of the Emergency Medical Care Committee as defined in Sections 1750 et seq. of the Health and Safety Code and shall have the following duties:

- Act in an advisory capacity to the Board of Supervisors and the Director of Health Services regarding County policies, programs, and standards for emergency medical care services throughout the County, including paramedic services.
- Establish appropriate criteria for evaluation and conduct continuous evaluations on the basis of these criteria of the impact and quality of emergency medical care services throughout Los Angeles County.
- Conduct studies of particular elements of the emergency medical care system as requested by the Board of Supervisors, the Director of Health Services or on its own initiative; delineate problems and deficiencies and to recommend appropriate solutions.
- Acquire and analyze the information necessary for measuring the impact and the quality of emergency medical care services.
- Report its findings, conclusions and recommendations to the Board of Supervisors at least every twelve months.
- Review and comment on plans and proposals for emergency medical care services prepared by County departments.
- Recommend, when the need arises, that Los Angeles County engage Independent contractors for the performance of specialized, temporary, or occasional services to the Commission which cannot be performed by members of the classified service, and for which the County otherwise has the authority to contract.
- Advise the Director and the Department of Health Services on the Policies, procedures, and standards to control the certification of mobile intensive care nurses and paramedics. Proposals of any public or private organization to initiate or modify a program of paramedic services or training

EMERGENCY MEDICAL SERVICES COMMISSION



Chief Raymond A. Mosack
Chairman
CA State Firefighters' Association



Carole A. Snyder, RN
Vice-Chair
Emergency Nurses Association



Mr. David Austin
L.A. County Ambulance
Association



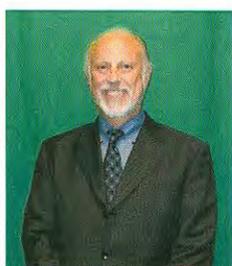
Chief Robert E. Barnes
Los Angeles County Police
Chiefs' Association



Mr. Frank Binch
Public Member
Fourth Supervisorial District



Erick H. Cheung, M.D.
Southern California
Psychiatric Society



Mr. Gerald B. Clute
Hospital Association of
Southern California



Robert Flashman, M.D.
Los Angeles County Medical
Association



Mr. Ron Hansen
Public Member
Third Supervisorial District



Clayton Kazan, M.D.
California Chapter-
American College of
Emergency Physicians



Mr. Daryl Parrish
League of California
Cities/L.A. County Division



Captain Andres Ramirez
Peace Officers Association
of Los Angeles County

No photo
available

Nurses Sanossian, M.D., FAHA
American Heart Association
Western States Affiliate

No photo
available

Chief Jon D. Thompson
Los Angeles Chapter-
Fire Chiefs Association

No photo
available

Areti Tillou, M.D.
Los Angeles Surgical Society



Mr. Gary Washburn
Public Member
Fifth Supervisorial District



Mr. Bernard S. Weintraub
Southern California Public
Health Association



Ms. Cathy Chidester
Executive Director



Ms. Marilyn Rideaux
Commission Liaison

Vacancies

Public Member, 1st Supervisorial District
Public Member, 2nd Supervisorial District
Public Member, 3rd Supervisorial District

New Appointments

Mr. Ron Hansen (10/29/2013)
Nurses Sanossian, M.D. (11/5/2013)

Public Member, 3rd Supervisorial District
American Heart Association, Western
States Affiliate

Re-Appointments

Mr. Gary Washburn (12/10/2013)

Public Member, 5th Supervisorial District

Resignations

Mr. Ron Hansen (6/30/2014)

Public Member, 3rd Supervisorial District

Elected Officers

Chief Raymond Mosack, Chair
Carole Snyder, RN, Vice Chair

1/16/2013 – Present
1/16/2013 – Present

Key Issues

The Commission addressed the following:

- A community concept introduced by the State EMS Authority, Community Paramedicine, which would allow paramedics to function outside of their customary role in ways that would facilitate more appropriate use of emergency care resources and or enhance access to primary care for medically underserved populations
- Long Beach Fire Department’s proposal to conduct a two-year Rapid Medic Deployment (RMD) pilot project
- Electronic Data Capturing – changes and additions of fire department collecting patient care data via electronic system
- Psychiatric Emergencies

Accomplishments

- Approved implementation of Long Beach Fire Department’s RMD pilot project without electronic patient care recording in place

Recommendations to the Board of Supervisors

- The Commission submitted a formal letter to the Board of Supervisors requesting that Measure B funds be allocated to a grant program for electronic data capturing.

Policies Approved

The Commission approved 28 Prehospital Care Polices between July 1, 2013 and May 31, 2014.

Standing Committees

- **Base Hospital Advisory Committee** is responsible for all matters regarding MICN certification and policy development pertinent to the practice, operation and administration of prehospital care.

Gerald Clute, Chair
Robert Flashman, MD, Vice Chair

During this fiscal year, the Base Hospital Advisory Committee (BHAC) reviewed and took action on 30 prehospital care policies with 29 of them resulting in approval. BHAC members initiated dialog regarding the processes of exchanging health information between hospitals and field personnel utilizing an electronic format. These discussions prompted the formation of an administrative task force to review the current processes and develop best practices for sharing health information. The EMS Agency and members of the BHAC (Prehospital Care Coordinators) worked in collaboration to define the process of evaluating base hospital (BH) data. The BH data dictionary was revised. Additionally, a set of standard reports was compiled and will be presented quarterly.

- **Data Advisory Committee** is responsible for all matters regarding quality of prehospital data, report generation, prehospital research and policy development impacting TEMIS.

Erick Cheung, M.D., Chair
Gary Washburn, Vice Chair (6/2013 – 1/2014)
Carole Snyder, Vice Chair (2/2014 – onward)

Established an ePCR steering committee whose membership includes fire chiefs, hospital CEOs, members of the EMS Commission, Los Angeles Ambulance Association and HASC representation to discuss and address the challenges related to ePCR interface and the collection and management of data.

- **Education Advisory Committee** is responsible for all matters regarding issues and policies pertinent to EMS curriculum and program development, implementation and evaluation.

Andres Ramirez, Chair (1/1/2014 – present)
Robert Flasman, M.D., Vice Chair (1/1/2014 – present)

Clayton Kazan, M.D., Chair (7/1/2013 – 12/31/2013)
Andres Ramirez, Vice Chair (7/1/2013 – 12/31/2013)

The committee reviewed and recommended approval of Ref 1013: EMS CE Provider Approval and Program Requirements. Committee reviewed Commission Plan for Improvement regarding education. The group supports the EMS Agency of storing a repository of best practices for orientation, mentoring programs, and skills retention. The committee received updates to system-wide QI studies and the California EMS System Core Measures report.

- **Provider Agency Advisory Committee** is responsible for all matters regarding prehospital licensure, certification and accreditation, and policy development pertinent to the practice, operation and administration of prehospital care.

David Austin, Vice Chair
Robert Barnes, EMSC

Disaster Pharmaceutical Cache: Disaster Pharmaceutical Caches (DPC) carried on public ALS units in Los Angeles County contain AtroPen auto-injectors and DUO DOTE auto-injectors. There were problems with Meridian Medicals production line (the sole manufacturer of these medications) and they ceased operation for an indeterminate amount of time. The FDA in conjunction with Meridian Medical extended the expiration dates of both medications 2 additional years.

Drug Shortages: The County experienced shortages of Dopamine, Atropine, Adenosine and Normal Saline IV solution. Although Dopamine, Atropine and Adenosine are now available, Normal Saline IV is still in short supply. The EMS agency has been assisting provider agencies plugging some of the holes with disaster relief supplies.

The EMS agency no longer offers local paramedic accreditation classes. Information is now available only online at the EMS Agency's webpage. This eliminated classroom time and expenses for provider agencies. The actual accreditation testing continues to be conducted at the EMS Agency.

Radio Days Only, implemented June 1, 2014. On specific days, when paramedics are required to establish base station contact, they are to utilize their radios only (not cellular phones). This is to test radio capabilities of all ALS units and base hospital radio systems within LA County.



EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate, and quality
emergency and disaster
medical services*



Health Services
<http://ems.dhs.lacounty.gov>

August 11, 2014

Jim Branchick
Chief Executive Officer
Kaiser Foundation – Downey Medical Center
9333 Imperial Highway
Downey, Ca 90242

Dear Mr. Branchick:

The Emergency Medical Services (EMS) Agency is pleased to announce that Kaiser Foundation – Downey Medical Center (KFB) has been designated as an Approved Stroke Center (ASC).

Effective Monday, August 4, 2014, Kaiser Foundation – Downey Medical Center began receiving patients who are transported by the 9-1-1 system and meet the criteria outlined in Reference No. 521, Stroke Patient Destination.

The EMS Agency requires each ASC to participate in data submission of all patients transported by 9-1-1 providers and meet the inclusion criteria as stated in the Los Angeles County EMS Agency Stroke Data Definitions.

Please complete and return the attached Confirmation Agreement within 15 days of receipt. Upon return, the EMS Agency will sign the Agreement and return the original to your facility.

Congratulations and thank you again for your commitment to the ASC program. If you have any questions, please feel free to contact me or Carolyn Naylor, Hospital Programs Coordinator, at (562) 347-1655.

Very truly yours,

William Koenig, M.D.
Medical Director

WK:RT:cn
08-02

Enclosure

c: Director, EMS Agency
Emergency Medical Services Commission
Medical Director Stroke Program, KFB
Stroke Program Coordinator, KFB



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd., Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate, and quality
emergency and disaster
medical services*

Health Services
<http://ems.dhs.lacounty.gov/>



August 7, 2014

Tom Lenahan, Fire Chief
Burbank Fire Department
311 E. Orange Grove Ave.
Burbank, CA 91502

Dear Chief Lenahan:

This is to confirm that Burbank Fire Department (BFD) has been approved by the Los Angeles County Emergency Medical Services (EMS) Agency for expanded utilization of intraosseous (IO) infusion for hypoperfusing pediatric and adult patients. Additionally, BFD is approved for a waiver to Reference No. 703, ALS Unit Inventory to carry and utilize 2% lidocaine 100mg/5ml without epinephrine preservative free for patients requiring pain management related to IO use. ALS providers shall carry a minimum of 200mgs. on each unit.

The EMS Agency is required by the State of California to evaluate and monitor the delivery of emergency medical services within Los Angeles County. The quality improvement process required for monitoring the implementation of the expanded IO program will be reviewed during your EMS Program Review and as deemed necessary by the EMS Agency.

Please contact me at (562) 347-1600 or Susan Mori at (562) 347-1609 for any questions or concerns.

Very truly yours,

William Koenig, MD
Medical Director

WK:sm
08-06

- c: Director, EMS Agency
- Assistant Director, EMS Agency
- Medical Director, BFD
- EMS Director, BFD
- Nurse Educator, BFD
- Paramedic Coordinator, BFD



EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To improve health
through leadership,
service and education*



Health Services
<http://ems.dhs.lacounty.gov>

August 6, 2014

TO: Distribution

FROM: Cathy Chidester
Director

SUBJECT: PRE-POSITIONED ANTIBIOTICS

This is to provide information regarding the Emergency Medical Services (EMS) Agency's plan for the replacement of the antibiotics (doxycycline) your city or department received in 2011 through the *Pre-positioning of Antibiotics Program*. As you recall, the United States Department of Homeland Security and the Centers for Disease Control and Prevention created the **Cities Readiness Initiative** as a first step in enhancing and increasing readiness of various essential entities/institutions in the event of a terrorist attack. Of foremost concern is the ability to respond in a timely manner to a bioterrorism attack, specifically *Bacillus Anthracis*, the pathogen that causes anthrax. In this scenario, the antibiotics must reach the affected population within 48 hours to have the greatest life-saving effect.

The doxycycline caches that were distributed in 2011 will be expiring in mid-late 2014. Due to decreased availability of doxycycline and reduced grant funding, we are now switching to Ciprofloxin as it is a lower cost alternative but similarly effective. We are currently in the process of procuring the Ciprofloxin but in the meantime, please do the following:

- **Do not dispose** of the expired doxycycline as the EMS Agency will be responsible for the disposal of the drugs.
- **Place this letter and the attached "Quarantine"** notice with the doxycycline when these expire.
- **Complete the attached *Storage and Distribution Plan*** and submit to John Ospital at jospital@dhs.lacounty.gov by September 30, 2014. We cannot perform the exchange without an updated plan. You will be notified once we are ready to do the exchange.

Your continued support, patience and participation are appreciated. Prepositioning of antibiotics for prophylaxis will strengthen the ability of all response agencies to quickly and safely provide protection for their workforce during anthrax or plague incident. Please call John Ospital at (562) 903-7069 if you have any questions or concerns.

Quarantine of Antibiotics

August 6, 2014

Page 2

CC:jo

Attachments

Distribution:

Chief/Chief Executive Officer, Each 9-1-1 Provider Agency
Chief Executive Officer, Each Hospital
Chief, Each Law Enforcement Agency
Chief, Los Angeles Office, Federal Bureau of Investigation
Sheriff, Los Angeles County Sheriff
Chief Executive Officer, Community Clinic Association of Los Angeles County
Emergency Services Coordinator, Each City
Chief Executive Officer, Los Angeles County
Executive Officer, Los Angeles County Board of Supervisors
Chief Medical Officer, Los Angeles County Department of Health Services
Director, Los Angeles County Department of Mental Health
Director and Health Officer, Los Angeles County Department of Public Health
Director, Los Angeles County Department of Coroner
Administrator, Los Angeles County Office of Emergency Management
County Counsel, Los Angeles County
Disaster Management Area Coordinators
Emergency Medical Services Commission
Regional Vice President, Hospital Association of Southern California

QUARANTINED

This expired doxycycline is a component of the Pre-positioned Antibiotic Program.

Please hold for LA County Department of Health Services.

Call John Ospital at (562) 903-7069 for more information

Department/Agency/Hospital/Clinic

Your Facility

Pre-Positioning of Antibiotics
Storage and Distribution Plan



Submitted to Los Angeles County Department of Health Services
Emergency Medical Services Agency (insert date)

TABLE OF CONTENTS

Background.....2

Introduction2

Purpose2

Goal2

Authorities.....2

Responsibilities2

Distribution Plan.....2

Attachment A7

Attachment B9

Attachment C10

Attachment C11

Department/Agency/Hospital Pre-Positioning of Antibiotics Plan

Background

In 2004, the United States Department of Homeland Security and the Centers for Disease Control and Prevention announced the Cities Readiness Initiative. This program is a first step by the federal government to increase and enhance readiness of selected cities to make full and effective use of the Strategic National Stockpile in the event of several possible types of catastrophic terrorist attacks. Of foremost concern is the ability to respond in a timely manner to a bioterrorism attack, specifically *Bacillus anthracis*, the organism that causes anthrax. In this case, antibiotics must reach the population within 48 hours to have the greatest life-saving effect.

Introduction

The pre-positioning of antibiotics for prophylaxis will strengthen the ability of all response agencies to provide protection for their work force during an anthrax incident quickly and safely. If additional antibiotics are needed, requests will be made through the Health Services Department Operations Center. The additional resources will come from other local, regional, and/or State caches or the Strategic National Stockpile (SNS).

This planning and preparation will speed subsequent distribution to the general public and reduce morbidity and mortality while assuring continuity of day-to-day operations. It will be the responsibility of each agency to store and secure the pre-positioned antibiotics in **BULK**. Distribution of the antibiotics to individuals will occur only upon the direct order of the County Health Officer.

Purpose

To provide ready access to antibiotics for first responder and other key personnel when the Los Angeles County Health Officer announces activation of the Employee Prophylaxis Plan. Notification to cities will be via activation of the County's Emergency Public Information Plan (EPI), the media, and the Emergency Management Information System (EMIS).

Goal

To plan for storing and distributing pre-positioned antibiotic caches within the Department/Agency/Hospital.

Authorities

Cities Readiness Initiative: See web site: <http://www.bt.cdc.gov>

Responsibilities

The County of Los Angeles Department of Health Services (DHS) will coordinate the Employee Prophylaxis Plan with the eighty-eight (88) cities, County Departments, hospitals and clinics which compose the Los Angeles County Operational Area and have emergency

management responsibilities. DHS will work with the appropriate pre-designated representatives to ensure compliance is met.

Distribution Plan

The medications, consisting of bottles of antibiotics, provided by the Los Angeles County Department of Health Services needs to be stored in **BULK** by the Department/Agency/Hospital/Hospital. Each bottle will contain fourteen (14) pills, which represents seven (7) days worth of medications in each bottle, at two (2) pills per day per person. Three (3) bottles of medications is allocated for each person identified as essential personnel: one (1) bottle for the employee and official and two (2) bottles for immediate family members.

The amount provided is for immediate needs until such time as POD sites are established and/or persons are identified as having/not having been exposed. The amount provided should not be considered as a complete course of treatment if exposure to Anthrax has occurred.

At the time of distribution to the employees, and Department/Agency/Hospital officials, an instruction sheet will be provided to each person (Attachment A). While doxycycline is not routinely used for children, it is appropriate when following the guidelines on the instruction sheet.

Women who are or think they might be pregnant and/or those with known allergies to doxycycline should not take the medication without first consulting a physician.

The Point of Contact for the Department/Agency/Hospital will be responsible for the maintenance of the distribution plan.

I. Identification of Essential Personnel

The Department/Agency/Hospital has identified the following number of personnel as critical to the Continuity of Government and providing essential services within the jurisdiction.

Department/Agency/Hospital Personnel	Total

Department/Agency/Hospital personnel and officials identified to receive medications are detailed in Attachment B.

II. Authority to Activate Plan

The Employee Prophylaxis Plan in the Los Angeles County Operational Area is activated upon order by the Public Health Officer for Los Angeles County. Upon the order of the Public Health Officer, the Point of Contact (POC) (insert title) in the Department/Agency/Hospital will initiate the agency's/department's distribution plan.

The Department/Agency/Hospital will be notified to activate the distribution plan by multiple methods including: EMIS, Disaster Management Area Coordinators (DMACs), local media and Los Angeles County's EPI system.

III. Storage Location

Antibiotics are to be stored in **BULK** in a secured, climate controlled environment in a temperature range of 68°F to 77°F. Medications are NOT to be distributed to individuals prior to the activation of the county's mass prophylaxis plan.

In the Department/Agency/Hospital, the prophylaxis medications will be stored at:

Name of Facility: _____

Address: _____

Location within Facility: _____
(Example: Heated/air conditioned storage room A, downstairs next to the firing range)

IV. Access to Storage Location

The following personnel have access to the storage location on a 24/7 basis:

Primary (Title): _____

Office Telephone: _____

Cell Phone: _____

1st Alternate (Title): _____

Office Telephone: _____

Cell Phone: _____

2nd Alternate (Title): _____

Office Telephone: _____

Cell Phone: _____

NOTE: If multiple storage locations are used please attach a listing for each site.

V. Monitoring

The Department/Agency/Hospital will submit a monthly report to DHS as to the status of the pre-positioned medications (Attachment C). The POC for the Department/Agency/Hospital will submit this report on behalf of the Department/Agency/Hospital. This report will be submitted no later than the 15th of the first month of each quarter, beginning in _____ 2006 and continuing thereafter in October, January, April, and July of subsequent years.

The pre-positioned antibiotics provided have a shelf life of approximately four (4) years. DHS will provide instructions for disposal of medications that have reached their expiration date. Medications should not be disposed of until DHS has approved of their disposal.

VI. Point of Contact (POC)

Primary Point of Contact

Name:

Title:

Telephone:

Cell/Mobile Phone:

FAX:

Email:

The 1st alternate Point of Contact is:

Name:

Title:

Telephone:

Cell/Mobile Phone:

FAX:

Email:

The 2nd alternate Point of Contact is:

Name:

Title:

Telephone:

Cell/Mobile Phone:

FAX:

Email:

VII. Distribution Process

Upon activation of the county's Prophylaxis Plan, the Department/Agency/Hospital will initiate the distribution process in the following manner:

Date:

1. The (insert title) will notify the Department/Agency/Hospital Director / Manager of the activation of the Prophylaxis Plan.
2. The Department/Agency/Hospital Director/Manager will approve the distribution of the unit-of-use bottles to pre-identified essential employees and officials.
3. Notification to employees will take place through department heads or the Agency's Director/Manager. Included in the notification process will be the location for pick-up, hours of operation and a telephone number for additional information.

4. The distribution of medications will take place at the following location(s):

Name of Facility: _____

Alternate Facility: _____

5. At the time of distribution, all persons will sign for medications (Attachment D) acknowledging their receipt and receipt of instructions.

6. The following person will be responsible for overseeing the distribution of the medications and will retain all records regarding the process.

Primary (Title): _____

Telephone: _____

1st Alternate (Title): _____

Telephone: _____

2nd Alternate (Title): _____

Telephone: _____

Attachment A

Attachment C

Department/Agency/Hospital _____

Antibiotics Monthly Monitoring Check Sheet

Authorized Individual's Name (printed) & Signature	July Date:		August Date:		September Date:		October Date:	
	Issued	On Hand	Issued	On Hand	Issued	On Hand	Issued	On Hand

Authorized Individual's Name (printed) & Signature	November Date:		December Date:		January Date:		February Date:	
	Issued	On Hand	Issued	On Hand	Issued	On Hand	Issued	On Hand

Authorized Individual's Name (printed) & Signature	March Date:		April Date:		May Date:		June Date:	
	Issued	On Hand	Issued	On Hand	Issued	On Hand	Issued	On Hand

Date: _____



EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To improve health
through leadership,
service and education*



Health Services
<http://ems.dhs.lacounty.gov>

July 24, 2014

Gloria J. Robertson
Office of Statewide Health Planning and Development
400 R. Street, Suite 330
Sacramento, CA 95811-6213

RE: Health Workforce Pilot Project Application #173

Dear Ms. Robertson:

Please accept this letter of support of the Community Paramedicine Health Workforce Pilot Project.

Paramedicine began as a pilot project in Los Angeles County in 1969. Paramedics responding to the ill and injured in the field to begin medical care was a novel concept spearheaded by Supervisor Kenneth Hahn. The foundation for the pilot project was the Wedsworth-Townsend Act, signed into law by Governor Ronald Reagan on July 14, 1970.

The opposition Governor Reagan met was similar to the Community Paramedicine pilot project. Many associations, including the physician, nurses, fire chiefs, and attorneys opposed the act, citing training, safety, and displacement of the current workforce.

The pilot project was successful! As the opposition subsided a carefully crafted scope of practice for the EMT-1 and paramedic was developed to meet the demands of the healthcare system in the last century. After 45 years, it is time to bring our systems into alignment with patient demand and new healthcare delivery models. Our Emergency Medical Services (EMS) systems should not be left to passively react to changes in healthcare and patient needs.

As in 1969, the proposed projects represent a forward thinking approach that will empower paramedics and patients with options to more effectively utilize our limited resources. The Medical oversight of the State of California EMS Authority and the Local EMS Agency Medical Director will ensure the safety and quality measures proposed. Patients will be protected and valuable data will determine a future course of improved care.

Since its inception, the paramedic and EMT programs have enhanced the roles of nurses and physicians by creating jobs in EMS oversight, education, quality improvement, and administration. These relationships continue to be critical to the success of the EMS services as part of the integrated healthcare system.

We appreciate the opportunity to comment and offer our support in working with the State on the implementation of these innovative health care delivery models.

Very truly yours,

William Koenig, M.D.
Medical Director

Cathy Chidester
Director

c: LA County EMS Commission
EMS Authority



EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*Ensuring timely,
compassionate, and quality
emergency and disaster
medical services.*



Health Services

<http://ems.dhs.lacounty.gov>

July 21, 2014

Michael DuRee, Fire Chief
Long Beach Fire Department
3205 Lakewood Boulevard
Long Beach, California 90808-1733

RE: UNIT RECONFIGURATION – APPROVAL

Dear Chief DuRee:

This is to advise you that Long Beach Fire Department's (LB) request to reconfigure the following Rescue Ambulances (RA) and Assessment Units (AU) is approved effective July 10, 2014:

- BLS Ambulance 3 – upgraded to Advanced Life Support (ALS) RA 3
- BLS Ambulance 12 – upgraded to ALS RA 12
- BLS Ambulance 22 – upgraded to ALS RA 22

- BLS Engine 1 – upgraded to AU 1
- BLS Engine 2 – upgraded to AU 2
- BLS Engine 3 – upgraded to AU 3
- BLS Engine 7 – upgraded to AU 7
- BLS Engine 9 – upgraded to AU 9
- BLS Engine 10 – upgraded to AU 10
- BLS Engine 11 – upgraded to AU 11
- BLS Engine 13 – upgraded to AU 13

On July 8, 2014, in preparation for LB to begin the approved Rapid Medic Deployment (RMD) Pilot Study, the Emergency Medical Services (EMS) Agency performed inventory inspections on the above paramedic units utilizing Reference No. 703, ALS Unit Inventory, for the proposed RAs and Reference No. 704, Assessment Unit Inventory, for the proposed Assessment Units. Although there were several inventory items missing at the time of these inspections, all missing items have been stocked and verification has been received from the LB paramedic coordinator.

Since LB's Medical Director, Stephen Shea, MD, has assumed total responsibility for LB's controlled substance program and the narcotic pharmaceuticals are purchased under Dr. Shea's medical license, this approval is granted with the understanding that each ALS RA mentioned above, is stocked with the required amounts of Morphine Sulfate and Midazolam, according to Reference No. 703, prior to placing into service.

The documentation on the EMS Report Form should indicate the provider code "LB" and unit designation of either "RA" for the Rescue Ambulance and "AU" for the Assessment Units. St. Mary Medical Center (SMM) is the assigned base hospital and has been notified of these additional units.

Confidential Quality Improvement Information: The information contained in this document is privileged and strictly confidential under State Law, including Evidence Code Section 1157.

Michael DuRee
July 21, 2014
Page 2

If you have any questions, please contact Gary Watson, Provider Agency / SFTP Program Coordinator, at (562) 347-1679.

Very truly yours,



Cathy Childester
Director

CC:gw
7-19

- c: Medical Director, Long Beach Fire Department
Deputy Chief, Operations – Mike Sarjeant
Paramedic Coordinator, Long Beach Fire Department
EMS Nurse Educator, Long Beach Fire Department
PCC, St. Mary Medical Center



EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

July 21, 2014

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

TO: Administrator
Each Los Angeles County Skilled Nursing Facility

FROM: Cathy Chidester, Director
Emergency Medical Services Agency

SUBJECT: **ACCESSING EMERGENCY MEDICAL TRANSPORTATION**

It has come to the attention of the Los Angeles County Emergency Medical Services (EMS) Agency that there appears to be confusion regarding when skilled nursing facilities should contact 9-1-1 versus a private ambulance company for treatment and transportation of acutely ill or injured patients. The purpose of this correspondence is to provide guidelines for accessing appropriate emergency medical transportation.

Appropriate Use of 9-1-1 EMS Providers

The primary EMS 9-1-1 provider for a geographical area is responsible for responding to medical emergencies that would routinely require "red lights and siren." In Los Angeles County, 9-1-1 providers are the fire departments responsible for a given area. When 9-1-1 is called, the primary 9-1-1 provider agency will either automatically dispatch paramedics or will determine, based on the information provided by the caller, if paramedics are necessary. At a minimum, a rescue vehicle staffed with Emergency Medical Technicians (EMTs) will be dispatched.

All EMTs and paramedics (whether employed by 9-1-1 provider agencies or private ambulance companies) are required to adhere to the policies and procedures outlined in the Los Angeles County Prehospital Care Policy Manual. One of these policies, Reference No. 808.1, Base Hospital Contact and Transport Criteria (Attachment I) specifies the signs, symptoms, and chief complaints or special circumstances of patients for whom base hospital contact is required for medical direction and/or patient destination. A base hospital is a designated hospital that provides medical treatment orders to paramedics. In addition, this policy delineates when transport to a hospital is required.

If you have a patient that meets the criteria outlined in "SECTION I – BASE CONTACT REQUIRED" of this policy, you must call 9-1-1 as these patients are presenting with an emergency condition that requires emergency transportation.

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate, and quality
emergency and disaster
medical services*

Health Services
<http://ems.dhs.lacounty.gov>



Non-emergency Ambulance Transportation

Private ambulance companies may provide two types of services – non-emergency and emergency transportation services. A non-emergency transportation service refers to the transport of stable patients (patients who do not appear to have a life-threatening emergency and who do not meet the criteria outlined in Section I of Reference No. 808.1. Do Not Resuscitate [DNR] status is not a reason to withhold emergency services). Skilled nursing facilities, as well as the general public, may call a private ambulance company for ambulance transportation when an individual needs the assistance of medical personnel and equipment, but does not require emergency transportation. When requesting ambulance transportation, you should indicate whether EMTs or paramedics are needed to accompany the patient in transport. The level of personnel needed is based on what treatment modalities are required by the patient and the scope of practice of EMTs and paramedics (Attachment II).

Emergency transportation services provided by private ambulance companies are done in conjunction with the primary 9-1-1 EMS provider agency. Many of the fire department 9-1-1 providers do not provide their own transportation. Instead, they contract with private ambulance companies to provide the transportation portion of the 9-1-1 response. Therefore, private ambulance companies respond in an emergency mode when requested to do so by the primary 9-1-1 provider. The public, including skilled nursing facilities, should not be calling private ambulance companies directly for emergency transportation. If a patient is considered to be having a life-threatening emergency, 9-1-1 should be called.

For your information, Section 7.16.100 of the County's Ambulance Ordinance prohibits private ambulance companies from responding to any emergency that would normally be considered an emergency 9-1-1 call for the authorized primary provider for that geographical area. If upon arrival to a scene of a call for non-emergency services and after assessment of the patient it is determined that a higher level of prehospital care intervention is needed, private ambulance company personnel are required to immediately notify the appropriate 9-1-1 dispatching agency. Private ambulance companies that do respond to such emergency calls are subject to Notices of Violation, Administrative Fines and possible actions against their license to operate in Los Angeles County.

Determining Patient Destination

The EMS Agency is aware that skilled nursing facilities often request that their patients be transported to a specific hospital for treatment. For patients with non-emergency medical conditions, private ambulance companies are able to accommodate these requests.

Chief Executive Officer
July 21, 2014
Page 3

For patients who either appear to be experiencing a life-threatening emergency or who meet the criteria outlined in Section I of Reference No. 808.1, patient destination is determined in accordance to guidelines outlined in Reference No. 502, Patient Destination (Attachment III). Patients with life-threatening emergencies must be transported to the most accessible receiving hospital (MAR) or designated specialty care center. However, if the 9-1-1 provider at the scene determines that the patient is (1) sufficiently stable to be transported to a more distant hospital and (2) it does not unreasonably remove the 9-1-1 provider from its area of primary response, the patient may be transported to the hospital requested by the skilled nursing facility. Skilled nursing facilities should not be calling private ambulance companies in emergencies to avoid having a patient taken to the closest facility. Private ambulance company EMTs and paramedics are required to follow the same destination policies as EMTs and paramedics of the 9-1-1 providers. However, you can be assured that the primary provider agencies will try to accommodate your requests if it falls within the above parameters.

Please review your policies and procedures related to the transfer of patients by ambulance to acute care facilities to ensure that they are in compliance with State and local regulations.

Should you have any questions, please contact Luanne Underwood, Ambulance Programs/Special Projects Manager at (562) 347-1681.

CC:lu:sr
6-43a

Attachments

- c. California Association of Health Facilities
Each Ambulance Company in Los Angeles County
Each 9-1-1 Provider Agency
Healthcare Association of Southern California
Emergency Medical Services Commission
State Department of Health Services

COMMITTEE REPORTS 3.1



EMERGENCY MEDICAL SERVICES COMMISSION BASE HOSPITAL ADVISORY COMMITTEE MINUTES October 8, 2014



REPRESENTATIVES		EMS AGENCY STAFF
<input checked="" type="checkbox"/> Clayton Kazan, MD,	EMS Commission	Deidre Gorospe
<input type="checkbox"/> Frank Binch, r	EMS Commission	Michele Hanley
<input checked="" type="checkbox"/> Nerses Sanossian, MD	EMS Commission	Cathy Jennings
<input checked="" type="checkbox"/> Lila Mier	County Hospital Region	Susan Mori
<input checked="" type="checkbox"/> Emerson Martell	County Hospital Region	Carolyn Naylor
<input checked="" type="checkbox"/> Jose Garcia	County Hospital Region, Alternate	Christy Preston
<input checked="" type="checkbox"/> Natalia Gamio	County Hospital Region, Alternate	Jacqueline Rifinburg
<input checked="" type="checkbox"/> Jessica Strange	Northern Region	Karen Rodgers
<input checked="" type="checkbox"/> Judy Grimaldi	Northern Region	Richard Tadeo
<input checked="" type="checkbox"/> Mark Baltau	Northern Region, Alternate	Michelle Williams
<input checked="" type="checkbox"/> Kristina Crews	Southern Region	
<input checked="" type="checkbox"/> Samantha Verga-Gates	Southern Region	
<input checked="" type="checkbox"/> Lindy Galloway	Southern Region, Alternate	
<input checked="" type="checkbox"/> Paula Rosenfield	Western Region	
<input checked="" type="checkbox"/> Ryan Burgess	Western Region	
<input type="checkbox"/> Sarah Koster	Western Region, Alternate	
<input type="checkbox"/> Rosie Romero	Western Region, Alternate	
<input checked="" type="checkbox"/> Laurie Sepke	Eastern Region	
<input checked="" type="checkbox"/> Alina Candal	Eastern Region	
<input checked="" type="checkbox"/> Jenny Van Slyke	Eastern Region, Alternate	
<input type="checkbox"/> Brain Hudson	Provider Agency Advisory Committee	
<input type="checkbox"/> Isaac Yang	Provider Agency Advisory Committee, Alt.	
<input checked="" type="checkbox"/> Jennifer Webb	MICN Representative	
<input type="checkbox"/> Jeff Warsler	MICN Representative, Alt.	
<input checked="" type="checkbox"/> Robin Goodman	Pediatric Advisory Committee	
<input type="checkbox"/> Kerry Gold-Tsakonas	Pediatric Advisory Committee, Alt.	
PREHOSPITAL CARE COORDINATORS		GUESTS
<input type="checkbox"/> Rachel Caffey (NRH)	<input checked="" type="checkbox"/> Dee Phillips (HMN)	Dr. Nicole Bosson
<input type="checkbox"/> Joanne Dolan (SMM)	<input checked="" type="checkbox"/> Jennifer Pickard (SMM)	
<input checked="" type="checkbox"/> Juliette Esswein, (AVH)	<input checked="" type="checkbox"/> Adrienne Roel (AMH)	
<input type="checkbox"/> Kelly Hauser (QVH)	<input checked="" type="checkbox"/> Heidi Ruff (NRH)	
<input type="checkbox"/> Kevin Lennox, (AMH)	<input type="checkbox"/> Robin Smilor (SFM)	
<input type="checkbox"/>	<input type="checkbox"/>	

1. CALL TO ORDER:

The meeting was called to order at 1:05 p.m. by Dr. Clayton Kazan.

2. APPROVAL OF MINUTES-August 13, 2014

M/S/C: (Grimaldi/??) Approve the August 13, 2014 meeting minutes as written.

3. INTRODUCTIONS/ANNOUNCEMENTS

Dr. Clayton Kazan announced the designation of St. Francis Medical Center as an Approved Stroke Center (ASC).

4. REPORTS & UPDATES

4.1 Dopamine Administration

Reference No. 703, ALS Unit Inventory has been modified to reflect Dopamine for field use as optional, with EMS Agency authorization. A

memo will be distributed to the EMS Community announcing this modification. Related prehospital policies have been revised to reflect the change.

Los Angeles Fire Department (CI) has submitted a request to remove dopamine from stock.

4.2 Approved Stroke Center Update

The Modified Los Angeles Prehospital Stroke Screen (mLAPSS) will remain the stroke assessment tool for prehospital care. This decision is based on evidence identifying it as a successful tool for prehospital screening, as well as satisfying regulatory requirements for EMS and Primary Stroke Centers.

Suggestions were offered to modify the current assessment tool to include patients with aphasia, and to extend the two-hour window Last Known Well Time to prehospital assessment.

The EMS Agency has received feedback from the ASCs related to delays in appropriate treatment of stroke patients when the patient is incapacitated and family or next of kin are unavailable. Prehospital personnel are requested to document contact information for family members or witnesses to facilitate early intervention.

4.3 Burbank Fire Department Pilot Study

Burbank Fire Department has been approved for expanded use of intraosseous (IO) on patients with poor perfusion. Prior to IO placement, lidocaine will be infused for procedural pain management.

4.4 EMS Update

Richard Tadeo announced the topics for EMS Update 2015, as selected by the EMS Update Task Force:

- Medical/Legal – objectives developed by nurse educators and Prehospital Care Coordinators
- Attitude and Excellence in Prehospital Care – developed with assistance from Heather Davis
- STEMI Activation

4.5 Ebola

A memo was distributed to the EMS community defining the guidelines for prehospital care and transport of patients with suspected symptoms of Ebola Virus Disease. The Agency will maintain frequent communication with hospitals and providers agencies as information is updated from the Department of Public Health.

5. UNFINISHED BUSINESS

Reference No. 815, Honoring Prehospital Do Not Resuscitate Orders and Physician Orders for Life Sustaining Treatment

Reference No. 815, Honoring Prehospital Do Not Resuscitate Orders and Physician Orders for Life Sustaining Treatment revisions reflect the incorporation of new State guidelines for Physician Orders for Life Sustaining Treatment (POLST).

M/S/C: (Van Slyke/Grimaldi) Approve Reference No. 815, Honoring Prehospital Do Not Resuscitate Orders and Physician Orders for Life Sustaining Treatment

6. NEW BUSINESS

Reference No. 806.1, Procedures Prior to Base Contact

Reference No. 806.1, Procedures Prior to Base Contact was reformatted for educational purposes only.

M/S/C: (Van Slyke/Crews) Approve Reference No. 806.1, Procedures Prior to Base Contact

7. OPEN DISCUSSION

There were no items offered for discussion.

8. NEXT MEETING: December 10, 2014

9. ADJOURNMENT: The meeting was adjourned at 2:15 p.m.

COMMITTEE REPORTS 3.2



EMERGENCY MEDICAL SERVICES COMMISSION DATA ADVISORY COMMITTEE

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

MEETING NOTICE

Date & Time: Wednesday, October 8, 2014 10:00 A.M.
Location: EMS Agency, First Floor Hearing Room
10100 Pioneer Boulevard
Santa Fe Springs, 90670-3736

This meeting of the EMS Commission's Data Advisory Committee meeting is open to the public. You may address the Committee about any agenda item before or during consideration of that item, or about any other item within the subject matter jurisdiction of the Committee.

DATA ADVISORY COMMITTEE DARK FOR OCTOBER 2014

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate, and quality,
emergency and disaster
medical services*



Health Services
<http://ems.dhs.lacounty.gov>



COMMITTEE REPORTS 3.3

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION
10100 Pioneer Blvd, Suite 200 Santa Fe Springs, CA 90670
(562) 347-1500 FAX (562) 941-5835



EDUCATION ADVISORY COMMITTEE

MEETING CANCELATION NOTICE

DATE: October 14, 2014
TO: Education Advisory Committee Members
SUBJECT: CANCELATION OF MEETING

Due to a lack of agenda items, the Education Advisory Committee meeting scheduled for October 15, 2014, is canceled.

INFORMATION IN LIEU OF MEETING:

Attached is a review and selection of topics by the EMS Update 2015 Task Force.

**Los Angeles County EMS Agency
EMS UPDATE 2015 – Recommended Topics**

TOPIC	Organization	Rationale	Task Force Comments	Action
1. Prehospital legal issues regarding: patients who are in custody, wanting to sign AMA, Minors	APCC EAC	Custody patients AMA – competent vs incompetent Minors – released at scene, AMA Documentation – best practice	No new information to present, covered in primary training, recommended to be part of continuing education program	Topic Nos. 1, 2 & 3 will be included in the update. Nurse Educators and PCCs will identify the specific topics that will be covered, draft the objectives and provide material for case reviews.
2. End of Life Care Forms	APCC EAC	There is a lack of awareness of the forms are and how to interpret them.	May be incorporated in Cardiac Arrest Management (Topic No. 16)	
3. IFTs for Specialty patients (AC, SRC and TCs) by 911 responders:	APCC EAC	Paramedic and base hospital role and scope of practice Medics are continually placed in compromising situations, changing of destinations, EMTALA, education to scope of practice.	2011 EMS Update had a topic on Role of the Base Hospital which received feedback that it was a “fill-in” topic. There is concern that this may be a regional rather than a countywide problem.	
4. ROSC	APCC	Physiological changes after ROSC, indications for decline in status and need for aggressive treatment	May be incorporated in Cardiac Arrest Management (Topic No. 16)	Will not be included.
5. Review of breath sounds	APCC	Misinterpretation of breath sounds – withholding fluids on septic patients Review of end stage respiratory failure	This is basic review with no new concepts to present.	Will not be included.
6. Overview of a systematic and thorough physical assessment	APCC	None indicated	This is basic review with no new concepts to present.	Will not be included.
7. Risk assessment for suicidal patients	APCC	Depression screening, suicide awareness and prevention to assist suicidal behavior amongst colleagues, friends and family.	Limited scope for EMS, unclear as to what benefit this education will have for prehospital care.	Consider for inclusion in Topic No. 1.
8. Pre-existing Vascular Access Devices (PVAD)	EAC	PVAD access during cardiac arrest; the medics are not comfortable using these vascular access devices.	There is de-emphasis on vascular access during cardiac arrest. This topic may be incorporated in the Cardiac Arrest Management (Topic No. 16)	Consider for inclusion in Topic No. 1.
9. SVT and other heart rhythms	EAC	Paramedics don’t get a lot of experience on reading cardiac rhythms.	This is basic review with no new concepts to present.	Will not be included.
10. Pacing/Cardioversion	EAC	None indicated.	These are basic skills, no new information to present.	Will not be included.
11. Wound packing/combat gauze	EAC	None indicated.	Very limited scope.	Will not be included.

TOPIC	Organization	Rationale	Task Force Comments	Action
12. Intra Osseous (IO)	EAC	None indicated.	Not all providers have IOs. Limited scope.	Will not be included.
13. Attitude/Excellence in prehospital care: What is it? How do we obtain it?	EAC	None indicated.	The focus should be on patient safety, team member empowerment, collective responsibility, etc.	Topics 13 & 14 will be included in the update. EMS Agency will collaborate with Heather Davis.
14. Excellence in Prehospital Care/Code of Ethics	EAC	To enhance accountability amongst EMS team members.	Combine with Topic No. 13.	
15. TEMS	EAC	Awareness and expectations for personnel.	Limited medical scope, mostly operational content, tourniquet was addressed at the last update.	Will not be included.
16. Cardiac Arrest Management	EMS Agency	New approach utilizing a "Pit-Crew" concept in CA management. This incorporates the concepts thought in previous update on ART/BART and Prehospital BLS cardiac arrest management.	This will focus management to preservation of brain function. This is an area where EMS can make a difference to the outcome of the cardiac arrest patient.	Will not be included.
17. STEMI Activation	EMS Agency	To provide a more specific criteria for Cath Lab activation from the prehospital setting.	This will provide paramedics additional knowledge and skill to assist the SRCs in determining whether or not to activate the Cath Lab Team.	This will be included in the update. The EMS Agency will develop the material.
18. Pediatric Burn Surge Policy	EMS Agency	This is a continuation of the Pediatric Surge Plan introduced in EMS Update 2011.	No new information to present.	Will not be included.
19. Versed/Chemical Restraints	EMS Agency	Reinforce the difference between behavioral complaints versus agitated delirium. EMS Staff have received multiple complaints regarding the inappropriate use of Versed on behavioral complaints.	Limited scope.	Will not be included as a single topic.

The EMS Agency will evaluate time allotted for each of the three topics as the training materials are developed and will consider additional topics as time permits.

Task Force Members:

Alina Candal, Joanne Dolan, Monica Bradley, Kristina Crews, Barry Jensen

Dr. Koenig, Dr. Bosson, Dr. Patel, Dr. Rosen, Michele Hanley, Jacqueline Rifenburg, Michelle Williams, Terry Crammer, Richard Tadeo



EMERGENCY MEDICAL SERVICES COMMISSION

PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday, October 15, 2014

MEMBERSHIP / ATTENDANCE

MEMBERS

- David Austin, Chair
- Robert Barnes, Vice-Chair
- Jon Thompson, Commissioner
- Ron Hansen, Commissioner
- Jodi Nevandro
 - Sean Stokes
- Jon O'Brien
 - Kevin Klar
 - Victoria Hernandez
- Kevin Costa
 - Susan Hayward
- Bob Yellen
 - Ivan Verastegui
- Dwayne Preston
 - Joanne Dolan
- Brian Hudson
 - Michael Murrey
- Jeffrey Elder
 - Douglas Zabilski
- Brandon Greene
 - Matthew Chelette
- Tina Crews
 - Alina Chandal
- Todd Tucker
 - James Michael
- Maurice Guillen
 - Ernie Foster
- Marc Eckstein, MD
 - Stephen Shea, MD
- Diane Baker
 - Vacant
- Laurie Lee-Brown

ORGANIZATION

- EMSC, Commissioner
- EMSC, Commissioner
- EMSC, Commissioner
- EMSC, Commissioner
- Area A
- Area A Alt
- Area B
- Area B, Alt.
- Area B Alt.
- Area C
- Area C Alt
- Area E
- Area E Alt.
- Area F
- Area F Alt.
- Area G (PAAC Rep to BHAC)
- Area G Alt. (PAAC Rep to BHAC, Alt.)
- Area H
- Area H Alt.
- Employed EMT-P Coordinator (LACAA)
- Employed EMT-P Coordinator, Alt. (LACAA)
- Prehospital Care Coordinator (BHAC)
- Prehospital Care Coordinator, Alt. (BHAC)
- Public Sector Paramedic (LAAFCA)
- Public Sector Paramedic, Alt. (LAAFCA)
- Private Sector EMT-P (LACAA)
- Private Sector EMT-P, Alt. (LACAA)
- Provider Agency Medical Director (Med Council)
- Provider Agency Medical Director, Alt. (Med Council)
- Private Sector Nurse Staffed Ambulance Program (LACAA)
- Private Sector Nurse Staffed Ambulance Program, Alt (LACAA)
- Representative to Medical Council and
- Representative to Data Advisory Committee

EMS AGENCY STAFF PRESENT

- | | |
|--------------------|------------------|
| William Koenig, MD | Cathy Chidester |
| Richard Tadeo | Stephanie Raby |
| Phillip Santos | Michele Hanley |
| Jacqui Rifenburg | Deidre Gorospe |
| Luanne Underwood | DiPesh Patel, MD |
| Anita Gowing | David Wells |
| John Telmos | Carolyn Naylor |
| Paula Rashi | Christy Preston |
| Cathlyn Jennings | Karen Rodgers |

OTHER ATTENDEES

- | | |
|-----------------|---------------------|
| Sean English | Pasadena FD |
| David Konieczny | McCormick Ambulance |
| Michael Beeghly | Santa Fe Springs FD |
| Luis Manjarrez | Gerber Ambulance |
| Trevor Stonum | MedCoast Ambulance |
| Margie Chidley | LA Co FD |
| Evie Anguiano | LA Co FD |
| Richard Roman | Compton FD |

LACAA – Los Angeles County Ambulance Association * LAAFCA – Los Angeles Area Fire Chiefs Association * BHAC – Base Hospital Advisory Committee * DAC – Data Advisory Committee

CALL TO ORDER: Chair David Austin called meeting to order at 1:00 p.m.

1. APPROVAL OF MINUTES (Costa/Baker) August 20, 2014 minutes were approved.

2. INTRODUCTIONS / ANNOUNCEMENTS

2.1 Civilian Investigator – Ambulance Licensing Section (John Telmos)

Anita Gowing was introduced as the newly employed Civilian Investigator working in the Ambulance Licensing Section and assisting in the Certification/Accreditation Section.

2.2 EMS Agency Data Reports (Cathy Chidester)

- Data reports are being placed on the EMS Agency webpage and distributed in emails.
- New look – Data divided into sections of the County.

2.3 Community Paramedic (*Cathy Chidester*)

- The EMS Agency received letter from the State EMS Authority recommending that the Director of *Office of Statewide Health Planning and Development* (OSHPD) to proceed with the approval of this pilot project.

3. REPORTS & UPDATES

3.1 Dopamine Shortage (*Jacqueline Rifenburg*)

- Due to minimal LA County usage and the continuous nationwide shortage, Medical Council has decided to move Dopamine from the mandatory ALS inventory to option ALS inventory.
- Approval to remove Dopamine will be at the discretion of each approved provider agency's Medical Director.
- Written notification to the EMS Agency of the provider agency's intent is required prior to removal.
- Removal of Dopamine does not affect Critical Care Transport providers.
- The following Prehospital Care policies reflect the inventory change and was presented as information only:
 - Reference No. 451.1a, Ambulance Vehicle Essential Medical Equipment
 - Reference No. 703, ALS Unit Inventory
 - Reference No. 706, ALS EMS Aircraft Inventory
 - Reference No. 1212, Treatment Protocol: Symptomatic Bradycardia (Adult)
 - Reference No. 1223, Treatment Protocol: Decompression Emergency
 - Reference No. 1242, Treatment Protocol: Allergic Reaction / Anaphylaxis
 - Reference No. 1244, Treatment Protocol: Chest Pain
 - Reference No. 1246, Treatment Protocol: Non-Traumatic Hypotension
 - Reference No. 1249, Treatment Protocol: Respiratory Distress

3.2 Provider Medical Director (*William Koenig, MD*)

- Clarification was made that the EMS Agency's Medical Director (Dr. Koenig) should not be listed as Medical Director for any provider agency.
- Dr. Koenig can remain listed as the "Drug Authorizing Physician" and provide SFTP program over-site for specific departments, until further notice.
- If there are any concerns, please contact Dr. Koenig.

3.3 Reference No. 410.1, Provider Agency Drug Authorization Physician Confirmation of Agreement to Purchase Drugs and Medical Devices – *Information Only* (*Jacqueline Rifenburg*)

Policy presented as information only.

- Added: Printed name of physician and his/her cellular phone number.

3.4 Reference No. 701, Supply and Resupply of Designated EMS Provider – *Information Only* (*Jacqueline Rifenburg*)

Policy presented as information only.

- Authority: Reference number updated
- Policy I.C.6.: replaced "morphine and midazolam" with "controlled drugs"

3.5 Reference No. 806.1, Procedures Prior To Base Contact – *Information Only* (*Jacqueline Rifenburg*)

Policy presented as information only.

- Numbering changes were made for easier understanding and education of treatment sequence.

3.6 Reference No. 1318, Medical Control Guideline: Intraosseous Access - Information Only
(Jacqueline Rifenburg)

Policy presented as information only.

- One public provider has received EMS Agency approval to pilot the use of IOs for conditions other than cardiac arrests.
- Guidelines: 7.: wording added to reflect the intravenous infusion of Lidocaine 2% for the specific use on patients other than cardiac arrest.

3.7 Ebola Update *(William Koenig, MD)*

(Due to the continuous changes in guidelines, the following information may not reflect current practices in recognition, patient handling and treatment of patients suspected of acquiring the Ebola virus. Providers are encouraged to seek up-to-date information from the local EMS Agency, Public Health Department and/or Center for Disease Control)

Letter dated October 6, 2014, was sent out to all provider agencies which included suggested guidelines for assessing patients for possible signs of Ebola.

Lengthy discussion on this topic included:

- Los Angeles County is not in an elevated risk for Ebola
- Recommendations that are coming from the EMS Agency and the Department of Public Health (DPH) are only if there is a positive Ebola case in Los Angeles County (currently there are none)
- Providers are encouraged to include the DPH when there is discussion on the types of PPE to purchase or utilize.
- DPH is very knowledgeable on the “donning” and “doffing” of PPE. Dr. Koenig informed this Committee that problems with contamination did not arise from the type of equipment, but rather how the equipment is used.
- DPH will be providing a demonstration on proper donning/doffing of PPE; public and private providers will be invited to participate.
- When ordering PPE for your department, providers should ensure that the PPE is impervious to fluids.
- The EMS Agency has created a webpage that is dedicated to Ebola information. (Listed under the Disaster Medical Services section of the EMS Agency’s webpage)
- Representative from Base Hospital Advisory Committee (BHAC) requested that providers who have a suspected Ebola patient, provide pre-notification to the receiving facility and inquire of possible alternate hospital entry points.
- Los Angeles County does not have Ebola receiving facilities: Providers are to transport suspected Ebola patients to the Most Accessible Receiving (MAR) facility.

3.8 EMS Update 2015 *(Richard Tadeo)*

Workgroup has selected three topics for next upcoming EMS Update:

- Medical/Legal – objectives developed by the nurse educators and Prehospital Care Coordinators
- Attitude and Excellence in Prehospital Care – developed with assistance from Heather Davis
- STEMI Activation

3.9 Stroke Update *(William Koenig, MD)*

Two issues were discussed during a previous Stroke Center meeting:

- Phone Numbers: Neurologists are requesting that on-scene paramedics obtain phone numbers of family who were present at time of Prehospital assessment (document on PCR). This would assist hospital physicians to pinpoint the Last Known Well times.
- MLAPSS: Los Angeles County is not dropping the MLAPSS screening process. Stroke systems are required to have one stroke screening process in place. Los Angeles County is reviewing the current MLAPSS and may be revising in the future.
Dr. Koenig encourages all providers to continue utilizing the MLAPSS scoring on all patients with Local Neuro symptoms.

4. UNFINISHED BUSINESS

There was no Unfinished Business.

5. NEW BUSINESS

5.1 Reference No. 226, Private Ambulance Provider Non 9-1-1 Medical Dispatch (*Phillip Santos*)

Policy reviewed and approved as presented.

M/S/C (Greene/Guillen): Approve Reference No. 226, Private Ambulance Provider Non 9-1-1 Medical Dispatch

5.2 Reference No. 226.1, Private Ambulance Provider Non 9-1-1 Medical Dispatch Caller Interview Guidelines (*Phillip Santos*)

Policy reviewed and approved with the following recommendation:

- Second Box from top: Replace “Signs and Symptoms of Shock” and “Sign and Symptoms of Stroke” to match wording in Reference No. 808.1, Base Hospital Contact and Transport Criteria – Field Reference.

M/S/C (O’Brian/Greene): Approve Reference No. 226.1, Private Ambulance Provider Non 9-1-1 Medical Dispatch Caller Interview Guidelines with the above recommendation.

5.3 Reference No. 406, Authorization for Paramedic Provider Status (*Jacqueline Rifenburg*)

Policy reviewed and approved as presented.

M/S/C (Preston/Hudson): Approve Reference No. 406, Authorization for Paramedic Provider Status

5.4 Reference No. 410, Drug Authorizing Physician For Provider Agencies (*Jacqueline Rifenburg*)

Policy reviewed and approved as presented.

M/S/C (Preston/Hudson): Approve Reference No. 410, Drug Authorizing Physician For Provider Agencies

6. OPEN DISCUSSION

6.1 Thermometers / ePCR Changes - Los Angeles Fire Department (*Jeffrey Elder*)

- Los Angeles Fire Department (LAFD) has recently stocked each of their units with non-contact, temporal thermometers.
- LAFD also added data fields in their electronic patient care record (ePCR) that would prompt questions that would assist in assessing patients for possible Ebola virus.

7. **NEXT MEETING:** December 17, 2014

8. **ADJOURNMENT:** Meeting adjourned at 2:15 p.m.

SUBJECT: **EMERGENCY MEDICAL SERVICES COMMISSION
ORDINANCE NO. 12332 – CHAPTER 3.20 OF
THE LOS ANGELES COUNTY CODE**

REFERENCE NO. 206

LOS ANGELES COUNTY CODE

LOS ANGELES COUNTY

EMERGENCY MEDICAL SERVICES COMMISSION

EFFECTIVE: 5-8-81

PAGE 1 OF 6

REVISED: 7-15-11

SUPERSEDES: 10-01-05

APPROVED:

Director, EMS Agency

Medical Director, EMS Agency

EMERGENCY MEDICAL SERVICES COMMISSION*

Sections:

3.20.010	Continuation – Composition
3.20.020	Length of service – Vacancy
3.20.040	Composition
3.20.050	Compensation
3.20.060	Chairperson
3.20.070	Functions and duties
3.20.080	Self-government – meetings
3.20.090	Staff

Note to Chapter 3.20.0

*For statutory provisions on county emergency medical care committees, see Health & Safety Code §1750 et seq. Editor's note: Ordinance 12332, passed April 7, 1981, entirely amended the provision of Ord. 4099 Art. 107, the Emergency Medical Services Commission, with the effect of discontinuing six sections. Legislative history for the discontinued sections includes: 20505a Ords. 12023 § 3 (part), 1979; 12040 § 1 (part), 1979. 20509 to 20511 Ords. 11179 § 1 (part), 1975; 12023 § 3 (part), 12201 § 1 (part), 1980. 20512 Ords. 12023 § 3 (part), 1979; 12040 § 1 (part), 1979; 12201 § 1 (part), 1980.

Section 3.20.010 Continuation – Composition.

- A. The Los Angeles County Emergency Medical Services Commission, which shall be referred to in this chapter as the "Commission", is continued in accordance with California Health and Safety Code Sections 1751 and 1752.
- B. The Commission shall have ~~46~~ 19 positions. A member of the Commission shall be appointed to a vacant position by, and serve at the pleasure of, the Board of Supervisors, which shall be referred to in this chapter as the "Board".
- C. Each person who is a member of the Commission on the effective date of this amendment shall serve at the pleasure of the Board for the remainder of his or her term of ~~two~~ four years (Ord. 90-0086 § 12(a), 1990; Ord. 12332 § 1 (part), 1981; Ord. 12201 § 1 (part), 1980; Ord. 12040 § 1 (part), 1979; Ord. 12023 § 3 (part), 1979; Ord. 11179 § 1 (part), 1975; Ord. 4099 Art. 107 § 20501, 1942.)

Section 3.20.020 Length of service – Vacancy. The provisions of this section shall become applicable to a position on the Commission at the expiration of the term of the member occupying that position on the effective date of the amendment codified in this section.

- A. Each member of the commission shall serve at the pleasure of the Board. Each position on the Commission shall become vacant every four years from the effective date of the amendment codified in this section.
- B. No member of the Commission may serve more than two consecutive full periods of service as specified in subsection A of this section. The Board may, by order,

extend this length of service or waive this limit for individuals or the Commission as a whole.

- C. A member's position on the Commission shall become vacant upon his or her death, resignation, or removal by the Board. In the case of such a vacancy, the Board shall appoint a successor to serve until the position next becomes vacant under subsection A of this section.
- D. The provisions of Chapter 5.12 of the County Code shall not apply to the Commission. (Ord. 2011-0062 § 2, 2011: Ord. 90-0086 § 12(b), 1990: Ord. 12332 §1 (part) 1981: Ord. 12201 § 1 (part), 1980: Ord. 12040 § 1 (part), 1979: Ord. 12023 § 3 (part), 1979: Ord. 11179 § 1 (part), 1975: Ord. 4099 Art. 107 § 20502, 1942.)

Section 3.20.040 Composition. The Commission shall be composed as follows:

- A. An emergency medical care physician in a paramedic base hospital nominated by the California Chapter of the American College of Emergency Physicians;
- B. A cardiologist nominated by the American Heart Association, Western States Affiliate;
- C. A mobile intensive care nurse nominated by the California Chapter of the Emergency Nurses Association;
- D. A hospital administrator nominated by the ~~Hospital~~ Healthcare Association of Southern California;
- E. A representative of a public provider agency nominated by the Los Angeles Chapter of California Fire Chiefs Association;
- F. A representative of a private provider agency nominated by the Los Angeles County Ambulance Association;
- G. An orthopedic, general or neurological surgeon nominated by the Los Angeles Surgical Society;
- H. A psychiatrist nominated by the Southern California Psychiatric Society;
- I. A physician nominated by the Los Angeles County Medical Association;
- J. A licensed paramedic nominated by the State Firefighters Association, Emergency Medical Services Committee.
- K. Five public members, one nominated by each member of the Board of Supervisors. No public member shall be a medical professional or affiliated with any of the other nominating agencies;
- L. A law enforcement representative nominated initially by the California Highway Patrol. After the first term of office for this position is completed, the law

enforcement representative shall be nominated by the Los Angeles County Peace Officers Association;

- M. A city manager nominated by the League of California Cities, Los Angeles County Chapter; (Ord. 99-0027 § 1, 1999: Ord. 12332 § 1 (part), 1981: Ord. 12201 § 1 (part), 1980: Ord. 12040 § 1 (part), 1979: Ord. 12023 § 3 (Part), 1979: Ord. 11179 § 1 (part), 1975: Ord. 4099 Art. 107 § 20504, 1942.)
- N. A police chief nominated by the Los Angeles Police Chiefs' Association;
- O. A representative nominated by the Southern California Public Health Association.

Section 3.20.050 Compensation. The members of the Commission shall serve without compensation. (Ord. 12332 § 1 (part), 1981: Ord. 12201 § 1 (part), 1980: Ord. 12040 § 1 (part), 1979: Ord. 12023 § 3 (Part), 1979: Ord. 11179 § 1 (part), 1975: Ord. 4099 Art. 107 § 20506, 1942.)

Section 3.20.060 Chairperson. The chairperson shall be appointed by the Commission members in accordance with the Commission's rules and regulations. (Ord. 12332 § 1 (part), 1981: Ord. 12201 § 1 (part), 1980: Ord. 12040 § 1 (part), 1979: Ord. 12023 § 3 (Part), 1979: Ord. 4099 Art. 107 § 20505(a), 1942.)

Section 3.20.070 Functions and duties.

- A. The Commission shall perform all of the functions of the emergency medical care committee as defined in Health and Safety Code Sections 1750, et seq., and shall have the following duties:
 - 1. ~~To~~ Act in an advisory capacity to the Board of Supervisors and the Director of Health Services regarding county policies programs, and standards for emergency medical care services throughout the county, including paramedic services;
 - 2. ~~To~~ Establish appropriate criteria for evaluation and to conduct continuous evaluation on the basis of these criteria of the impact and quality of emergency medical care services throughout the county;
 - 3. ~~To~~ Conduct studies of particular elements of the emergency medical care system as requested by the Board of Supervisors, the Director of Health Services or on its own initiative; to delineate problems and deficiencies and to recommend appropriate solutions;
 - 4. ~~To~~ Acquire and analyze the information necessary for measuring the impact and the quality of emergency medical care services;
 - 5. ~~To~~ Report its findings, conclusions, and recommendations to the Board of Supervisors at least every 12 months;

6. ~~To~~ Review and comment on plans and proposals for emergency medical care services prepared by County departments;
 7. ~~To~~ Recommend, when the need arises, that the County engage independent contractors for the performance of specialized temporary or occasional services to the Commission which cannot be performed by members of the classified service, and for which the County otherwise has the authority to contract;
 8. ~~To~~ Advise the Department of Health services and its Director on the following matters:
 - a. Policies, procedures, and standards to control the certification of mobile intensive care nurses and paramedics;
 - b. Proposals of any public or private organization to initiate or modify a program of paramedic services or training;
 9. To arbitrate differences in the field of paramedic services and training between all sectors of the community, including, but not limited to, county agencies, municipalities, public safety agencies, community colleges, hospitals, private companies, and physicians.
- B. A decision of the Commission regarding a matter which the Commission hears under its arbitration function pursuant to subparagraph 9 herein above will be final and binding upon the parties who appeared before the commission on the matter unless the Board of Supervisors at any time promulgates policy which is inconsistent with such determination. ~~Further, The~~ Commission shall refer to the Board of Supervisors and any other affected provider agency any such decision of the Commission which will either affect the budget of the county, or any other provider agency, for the paramedic program, or operate to change an existing county-approved policy. Such decision shall not become final and binding unless adopted by the Board of Supervisors. Additionally, any such decision of the Commission shall be advisory only if its implementation will affect any County paramedic program matter which the County Health Officer, the local Emergency Medical Services Agency, or Board of Supervisors has power to regulate pursuant to Health and Safety Code Sections 1480 and 1797.200, ~~et seq. and Health and Safety Code Sections 1797.200, et seq. (Ord. 12332 § 1 (part), 1981: Ord. 12201 § 1 (part), 1980: Ord. 12040 § 1 (part), 1979: Ord. 12023 § 3 (part), 1979: Ord. 11909 § 1, 1979: Ord. 11179 § 1 (part), 1975: Ord. 4099 Art. 107 § 20505, 1942.)~~

Section 3.20.080 Self-government – Meetings. The Commission shall prepare and adopt rules and regulations for the internal government of its business and designating the time and place of holding its meetings, provided that such rules and regulations are not inconsistent with this or any other ordinance or statute. (Ord. 12332 § 1 (part), 1981: Ord. 12201 § 1 (part), 1980: Ord. 12040 § 1 (part), 1979: Ord. 12023 § 3 (Part), 1979: Ord. 11179 § 1 (part), 1975: Ord. 4099 Art. 107 § 20507, 1942.)

Section 3.20.090 Staff. The Director of Health Services shall provide the staff for the Commission and subcommittees thereof. (Ord. 12332 § 1 (part), 1981: Ord. 12201 § 1 (part), 1980: Ord. 12040 § 1 (part), 1979: Ord. 12023 § 3 (part), 1979: Ord. 11179 §1 (part), 1975: Ord. 4099 Art. 107 § 20508, 1942.)

CROSS REFERENCES:

Prehospital Care Manual:

- Ref. No. 201, **Medical Management of Prehospital Care**
- Ref. No. 214 **Base Hospital and Provider Agency Reporting Responsibilities**
- Ref. No. 310, **Prehospital Care Coordinator**
- Ref. No. 411, **Provider Agency Medical Director**
- Ref. No. 610, **Retention of Prehospital Care Records**
- Ref. No. 620, **EMS Quality Improvement Program (EQIP)**
- Ref. No. 620.1 **EMS Quality Improvement Program (EQIP) Plan**
- Ref. No. 1013 **EMS Continuing Education (CE) Provider Approval and Program Requirements**

POLICIES 4.2

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: SUMMARY OF COMMENTS RECEIVED

REFERENCE NO 202.1

Reference No. 406, Authorization for Paramedic Provider Status

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Entire Policy	PAAC 10/15/14	Excepted and approved as is, no changes	

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **AUTHORIZATION FOR PARAMEDIC
PROVIDER STATUS**

REFERENCE NO. 406

PURPOSE: To outline the criteria to be approved as a paramedic provider in Los Angeles County.

AUTHORITY: Health & Safety Code, Division 2.5, Sections 1797.52, 1797.94, 1797.178, 1797.180, 1797.201
California Code of Regulations, Title 22, Sections 100166, 100167, 100169, 100400 and 100402

PRINCIPLE:

- I. Providers applying for paramedic provider status must complete the application process in its entirety, including written approval from the EMS Agency prior to commencing operations.

POLICY:

- I. Eligibility Requirements

- A. In order to apply for paramedic provider status, a fire department must be authorized by the governing body of the jurisdiction to provide 9-1-1 emergency services.
- B. A private ambulance company must be licensed by the County of Los Angeles as a basic life support (BLS) provider for a minimum of twenty-four months during which time said license has been maintained without violations of any applicable provisions, standards, or requirements of state statute or regulation, or of the Los Angeles County Code or local policies and procedures. Each of the company's ambulance vehicles that operate within the County of Los Angeles shall also be licensed by the County.

- II. Application Process

- A. The applicant shall submit a written request for approval of paramedic provider status to the Director of the Los Angeles County EMS Agency. The request shall include the following:
 1. The desired implementation date.
 2. The number of advanced life support (ALS) units desired and the proposed location for each unit.
 3. The preferred base hospital assignment, subject to EMS Agency approval.

EFFECTIVE: 06-01-82
REVISED: 12-1-14
SUPERSEDES: 3-15-11

PAGE 1 OF 4

APPROVED: _____

Director, EMS Agency

Medical Director, EMS Agency

4. Other information pertinent to the proposed paramedic program (e.g., number of personnel licensed and accredited as paramedics, the number of personnel requiring paramedic training, and the name and contact information for the EMS educator, paramedic coordinator and nurse educator, (if applicable).
5. The name and contact information for the Provider Agency Medical Director, or Drug Authorizing Physician, under whose license the provider agency will procure equipment, pharmaceuticals (both scheduled and non-scheduled) and medical devices.

B. Provider Agency Responsibilities

1. Provide emergency medical service response on a continuous 24-hour per day basis unless otherwise approved by the EMS Agency. Approved ALS providers may submit a written request, including justification, to the EMS Agency for consideration to waive the 24-hours/day requirement. Waivers will be granted on a case-by-case basis.
2. Submit the following documents to the EMS Agency:
 - a. Quality Improvement (QI) Plan
 - b. Description of the communications equipment that will be used
 - c. A controlled substance policy that outlines how scheduled pharmaceuticals will be procured, stored, secured, and distributed. The policy shall include the procedures for handling any lost, broken or tampered scheduled pharmaceuticals.
 - d. A supply/resupply policy outlining the method for purchasing and storing non-scheduled pharmaceuticals and medical devices.
 - e. A plan ensuring that all personnel involved in the ALS program are oriented to the base hospital's operation.
 - f. A policy/procedure to ensure that all ALS units and paramedic personnel are visibly identified as such.
 - g. A list of all the ALS, Assessment and Reserve units, numerical unit designation, physical address and contact number for the location of each unit.

NOTE: The above information needed for approval is due to the EMS Agency as a complete packet within 30 (thirty) days of receipt of letter and application packet from the EMS Agency acknowledging the request for approval. If a complete application packet not received within that 30 (thirty) day period the request is denied, a subsequent request for approval will not be accepted for 90 (ninety) days.

3. Utilize and maintain communications as specified by the EMS Agency.
4. Arrange for a base hospital orientation. (This may be facilitated in conjunction with the EMS Agency).

5. Procure and maintain equipment, supplies and pharmaceuticals for each ALS, Assessment and Reserve unit(s) as outlined in the applicable policies. Each ALS, Assessment and Reserve unit shall undergo a unit inventory inspection and be approved by the EMS Agency prior to deployment.
6. Ensure that all deployed unit(s) (ALS, Assessment and Reserve) are fully stocked at all times.
7. Private providers shall maintain a written agreement with the Los Angeles County EMS Agency to participate in the ALS program. This agreement shall be reviewed every two years and may be changed, renewed, canceled or otherwise modified as necessary.
8. Appoint a Paramedic Coordinator to act as the liaison with the EMS Agency and the assigned base hospital.
9. Ensure that the paramedic coordinator attends EMS Orientation within six (6) months of being appointed. (EMS Orientation dates are prescheduled and held on a quarterly basis).
10. Staff each approved ALS unit with a minimum of two licensed and locally accredited paramedics in accordance with Ref. No. 408, Advanced Life Support Unit Staffing.
11. A public provider will only be considered for approval for the assessment unit configuration if a paramedic program consisting of a two-paramedic ALS unit response configuration is in place. The provider shall comply with Reference No. 416, Assessment Unit.

C. EMS Agency Responsibilities:

1. Acknowledge the applicant's request in writing and furnish a generic copy of the applicable EMT-Paramedic Service Provider Agreement or Medical Control Agreement. A finalized agreement will be mailed under separate cover for execution. A fully executed agreement must be in place prior to program implementation.
2. Approve or reject the request for paramedic provider status approval based on the EMS Agency's review of the documents submitted by the applicant as outlined in "Provider Agency Responsibilities".
3. Coordinate initial EMS Patient Care Record (PCR) training with the paramedic coordinator or their designee.
4. Periodically perform surveys and reviews, including field observation, to ensure compliance with state law and regulations, local policies, and if applicable, the EMT-Paramedic Service Provider Agreement.

5. Deny, suspend, or revoke the approval of a paramedic provider for failure to comply with applicable policies, procedures and regulations.
6. Conduct ALS, Assessment and Reserve unit inventory inspections prior to approving ALS, Assessment and Reserve units for deployment.

III. Program Updates/Modifications

- A. Provider agencies may request to place additional ALS, Assessment and Reserve units into service and shall notify the EMS Agency for inventory inspection and approval. Requests and inventory inspections shall be done prior to deployment.
- B. Provider agencies shall notify the EMS Agency for any long-term relocation of existing ALS units or reduction in the number of ALS units.
- C. Private provider agencies that have been operational as an ALS provider for at least one year may request approval from the EMS Agency to implement the 1:1 staffing configuration (one EMT/one paramedic) for interfacility transports. In order to be considered for the 1:1 staffing configuration, the provider agency must successfully complete a six-month probationary period for their ALS program and pass an ALS site review conducted by the EMS Agency. The 1:1 staffing configuration is contingent on meeting all the specific program requirements and EMS Agency approval.
- D. Provider agencies desiring to change unit configurations shall notify the EMS Agency for inventory inspection and approval.

CROSS REFERENCES:

Prehospital Care Manual:

- Ref. No. 214, **Base Hospital and Provider Agency Reporting Responsibilities**
- Ref. No. 408, **Advanced Life Support (ALS) Unit Staffing**
- Ref. No. 409, **Reporting ALS Unit Staffing Exceptions**
- Ref. No. 411, **Provider Agency Medical Director**
- Ref. No. 620, **EMS Quality Improvement Program**
- Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
- Ref. No. 702, **Controlled Drugs Carried on ALS Units**
- Ref. No. 703, **ALS Unit Inventory**
- Ref. No. 704, **Assessment Unit Inventory**
- Ref. No. 710, **Basic Life Support Ambulance Equipment**
- Ref. No. 716, **Paramedic Communications System**
- Ref. No. 803, **Los Angeles County Paramedic Scope of Practice**

Los Angeles County Code, Title 7. Business Licenses, Chapter 7.16, Ambulances

POLICIES 4.3

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: SUMMARY OF COMMENTS RECEIVED

REFERENCE NO 202.1

Reference No. 410, Drug Authorizing Physician for Provider Agencies

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Entire Policy	PAAC 10/15/14	Accepted and approved as is, no changes	

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **DRUG AUTHORIZING PHYSICIAN FOR
PROVIDER AGENCIES**

REFERENCE NO. 410

PURPOSE: To provide an orientation for physicians who agree to authorize the purchase of drugs, medical devices and controlled substances for a paramedic provider agency.

AUTHORITY: Health & Safety Code 1797, et seq.
Title 22, California Code of Regulations, Section 100169(a)(1), 100145(c)

DEFINITION:

Drug Authorizing Physician: A physician who utilizes their medical license and Drug Enforcement Administration (DEA) number to purchase drugs, medical devices and controlled substances for an approved EMS provider agency in Los Angeles County. This role is primarily limited to drug purchases and they are not required to meet the criteria for Provider Agency Medical Director.

Provider Agency Medical Director: A physician designated by an approved EMS Provider Agency to provide medical oversight of field care and who meets the criteria outlined in Reference No. 411. A Provider Agency Medical Director may also agree to act as a Drug Authorizing Physician.

Controlled Drugs: A controlled substance is any drug defined in the categories of the Controlled Substances Act of 1970 including opium and its derivatives, hallucinogens, depressants, and stimulants. In Los Angeles County, the provider agency controlled drugs are outlined in Reference No. 702, Controlled Drugs Carried on ALS Units.

PRINCIPLES:

1. Provider agencies may obtain controlled substances from a physician who agrees to authorize the procurement of controlled substances under their DEA registration.
2. Drug Authorizing Physicians understand shall sign Reference 410.1 to acknowledge in writing that they are responsible for purchasing, storing, and distributing controlled drugs for the provider agency in accordance with Reference No. 702, Controlled Drugs Carried on ALS Units.
3. The controlled drugs purchased by the Drug Authorizing Physician are restricted to those listed in Ref. No. 703 ALS Unit Inventory.

POLICY:

- I. Procedure to Become a Drug Authorizing Physician for Provider Agencies

EFFECTIVE: 12-1-09
REVISED: 12-1-14
SUPERSEDES: 12-1-09

PAGE 1 OF 3

APPROVED: _____

Director, EMS Agency

Medical Director, EMS Agency

- A. The provider agency shall submit a letter, on departmental letterhead, of intent to purchase drugs, medical devices, and controlled drugs under a Drug Authorizing Physician to include:
 - 1. The name of the physician who will assume this responsibility.
 - 2. The proposed date of the changeover from the EMS Agency Medical Director to the Drug Authorizing Physician.
 - 3. A signed Confirmation of Agreement to Purchase Drugs and Medical Supplies (Ref. No. 410.1).
 - 4. A narcotic policy revised to indicate how controlled drugs will be purchased and stored under the Drug Authorizing Physician in accordance with Federal and State regulations.
 - 5. The name, address, and telephone number of the key contact for the controlled substance supplier.

- B. The following must take place prior to the change from the EMS Agency Medical Director to the Drug Authorizing Physician:
 - 1. The Drug Authorizing Physician shall meet with the EMS Agency Medical Director.
 - 2. The provider agency shall return any drugs previously obtained at a County Hospital pharmacy to the issuing pharmacy.
 - 3. EMS Agency staff will conduct a site visit to assess controlled drug storage and security.

- II. Procedure for Returning Controlled Substances Previously Issued by a County Hospital Pharmacy:
 - A. The provider agency shall fax the controlled drug logs showing the current inventory levels to the Prehospital Care Section of the EMS Agency at (562) 946-6594.
 - B. EMS Agency staff will review the logs and contact the issuing pharmacy to arrange a mutually agreed-upon date and time for the provider agency to return the drugs.
 - C. Once the logs are reviewed and validated, EMS Agency staff will give the provider agency the documentation needed to return the controlled substances. This authorization will also serve as notification to the County pharmacy to delete the provider agency from the list of those approved to obtain controlled substances.

SUBJECT: **DRUG AUTHORIZING PHYSICIAN FOR
PROVIDER AGENCIES**

REFERENCE NO. 410

- D. The provider agency will return the drugs to the issuing pharmacy along with any blue copies of the EMS Report Form needed to account for drugs not in inventory due to administration in the field.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 410.1, **Drug Authorizing Physician Confirmation of Agreement Form**

Ref. No. 411, **Provider Agency Medical Director**

Ref. No. 702, **Controlled Drugs Carried on ALS Units**

Ref. No. 703, **ALS Unit Inventory**

SUBJECT: **AUTHORIZATION AND CLASSIFICATION
OF EMS AIRCRAFT**

REFERENCE NO. 418

PURPOSE: To define the criteria that must be met in order to be approved and classified as an EMS aircraft provider in the County of Los Angeles.

AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 8, Section 100276-100306.
Los Angeles County, Code of Ordinances, Title 7, Business Licenses, Division 2, Chapter 7.16, Ambulances

DEFINITIONS:

Advanced Life Support (ALS): Definitive prehospital emergency medical care approved by the local EMS Agency including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital or if applicable, Reference No. 806.1, Procedures Prior to Base Contact, or if an approved Standing Field Treatment Protocol provider, SFTPs as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the staff of that hospital.

Basic Life Support (BLS): Those procedures and skills contained in the EMT-I scope of practice, including emergency first aid and cardiopulmonary resuscitation.

Air Ambulance: Any aircraft which has been designated, constructed, modified or equipped, and is used for the purpose of responding to emergency calls and transporting critically ill or injured patients whose medical flight crew has a minimum two (2) attendants whose scope of practice authorizes them to function at the ALS level.

Air Ambulance Service: Air transportation service, public or private, which utilizes aircraft specially constructed, modified or equipped to transport critically ill or injured patients. This includes the provision of qualified flight crews and aircraft maintenance.

Air Rescue Service: Air Service used for the purpose of responding to emergency calls, requiring special equipment and/or expertise due to the terrain and or circumstances of the incident, i.e., mountain rescue, water rescue, etc.

Air Ambulance or Air Rescue Service Provider: The individual or group that owns and/or operates an air ambulance or air rescue service and which is authorized by the EMS Agency as a provider.

Back-Up Air Ambulance Provider: An agency which has been designated by the local EMS Agency to provide back-up or second call emergency air ambulance service when requested to

EFFECTIVE DATE: 9-1-03

PAGE 1 OF 10

REVISED: xx-xx-14

SUPERCEDES: 5-1-12

APPROVED BY:

Director, EMS Agency

Medical Director, EMS Agency

do so by the designated primary provider agency or the designated primary air ambulance provider.

Emergency Medical Services (EMS) Aircraft: Any aircraft utilized for the purpose of prehospital emergency patient response and transport. EMS aircraft includes air ambulances and all categories of rescue aircraft.

Rescue Aircraft: An aircraft whose usual function is not prehospital emergency patient transport but which may be utilized, in compliance with local EMS policy, for prehospital emergency patient transfer when use of an air or ground ambulance is inappropriate or unavailable. Rescue aircraft includes ALS, BLS and auxiliary rescue aircraft.

Auxiliary Rescue Aircraft: A rescue aircraft which does not have a medical flight crew or whose medical flight crew does not meet the minimum requirements of an EMT-I.

Classifying and Authorizing EMS Agency: The Los Angeles County EMS Agency, which classifies EMS aircraft into categories and approves utilization of such aircraft within its jurisdiction.

Designated Dispatch Center: An agency which has been designated by the local EMS agency for the purpose of coordinating air ambulance or rescue aircraft response to the scene of a medical or traumatic emergency within the jurisdiction of the local EMS agency.

Medical Flight Crew: The individual(s), excluding the pilot, specifically assigned to care for the patient during the aircraft transport.

Primary Provider Agency: The provider agency authorized to provide 9-1-1 emergency medical services within a city or unincorporated area of Los Angeles County by the governmental authority responsible for that geographic area.

Immediately Available: Medical flight crew within the specified area of the EMS aircraft and responding without delay when dispatched to a patient response.

PRINCIPLES:

1. The Los Angeles County EMS Agency is responsible for the integration of EMS aircraft into the Los Angeles County EMS patient transport system and for the development of policies and procedures related to the integration of this specialized resource. EMS aircraft operating in Los Angeles County must be classified and authorized by the EMS Agency in order to provide prehospital patient transport.
2. EMS aircraft providers (excluding agencies of the federal government) who provide or make available prehospital air transport or medical personnel, either directly or indirectly, or any hospital where an EMS aircraft is based, housed, or stationed permanently or temporarily, shall adhere to all applicable federal, state, and local statutes, ordinances, policies, and procedures related to EMS aircraft operations, including qualifications of flight crews and aircraft maintenance.
3. No EMS aircraft shall respond to an incident without formal dispatch from a designated dispatch center or request for the primary provider agency responsible for the area in which the incident is located.

4. A planned and structured initial and recurrent training program specific to the air ambulance/air rescue service mission and scope of care of the medical flight crew must be ensured and documented for all regularly scheduled medical flight crew members.
5. Any privately owned/operated air ambulance service providing EMS services in Los Angeles County shall be licensed in accordance with Los Angeles County Code, Chapter 7.16, Ambulances.

POLICY:

I. General Provisions

- A. No person or organization shall provide or hold themselves out as providing prehospital EMS aircraft or EMS air rescue services unless that person or organization has aircraft which have been designated by the EMS agency.
 - B. EMS aircraft shall be classified by the EMS Agency into one of the following categories:
 1. Air Ambulance
 2. ALS Rescue Aircraft
 3. BLS Rescue Aircraft
 4. Auxiliary Rescue Aircraft
 - C. EMS aircraft classification will be reviewed in accordance with this policy and reclassification may occur anytime there is a transfer of ownership or a change in the aircraft's capability.
 - D. The EMS Agency shall maintain an inventory of authorized EMS aircraft providers. This inventory shall include, but not be limited to, the number and type of authorized EMS aircraft, the patient capacity of each EMS aircraft, and the level of patient care provided by EMS aircraft personnel for each authorized EMS aircraft provider.
 - E. The EMS Agency shall have written agreements with air ambulance providers routinely serving Los Angeles County which may be incorporated and considered a part of the medical control agreements. These agreements shall specify the conditions under which air ambulance designation is maintained and assurance of compliance with all local, state and federal rules and regulations.
 - F. When prehospital aircraft are routinely requested from outside Los Angeles County, interagency agreements shall be executed between the County of Los Angeles and County in which the air ambulance provider is operationally based. The air ambulance provider shall attend a Los Angeles County EMS Agency orientation to include review of policies, procedures and interface with the Medical Alert Center (MAC). Pilot flight orientation to helipads shall be arranged by the EMS Agency with a currently approved Los Angeles County Air Operations Provider.
-

-
- G. When aeromedical prehospital response is occasionally requested from outside Los Angeles County, the medical flight crew may perform their basic scope of practice provided that medical control is maintained by the jurisdiction of origin, and an intercounty agreement exists between the County of Los Angeles and the County in which the air ambulance provider is operationally based. The air ambulance provider shall attend a Los Angeles County EMS Agency orientation to include review of policies, procedures and interface with the Medical Alert Center. Pilot flight orientation to helipads shall be arranged by the EMS Agency with a currently approved Los Angeles County Air Operations Provider.
 - H. Auxiliary rescue aircraft shall not transport patients unless all other resources have been exhausted and there are no other acceptable means for patient transport to an appropriate receiving facility. The EMS Agency shall be notified in writing of all such occurrences. Such notifications shall include the date, time, sequence number and events surrounding the incident.
 - I. Each provider agency shall submit quarterly data on all EMS responses utilizing the EMS Agency approved data reporting template. Data is due no later than 30 calendar days after the end of each quarter.
- II. Personnel/Training
- A. The medical flight crew of an EMS aircraft shall be immediately available and have as its primary responsibility the treatment and transport of EMS patients when the aircraft is available for EMS response for a given shift. The EMS aircraft provider shall ensure that the medical flight crew has met all initial and recurrent training requirements.
 - B. The medical flight crew of an air ambulance shall, at minimum, consist of two attendants in any combination of the following, whose scope of practice authorizes them to function at the ALS level:
 - 1. A physician currently licensed in the State of California who is board certified in emergency medicine or has satisfied the requirements to take the emergency medicine board examination; unless otherwise authorized by the EMS Agency Medical Director.
 - 2. A physician currently licensed in the state of California and who is current in the following:
 - a. ACLS and PALS or equivalent curriculum; and
 - b. BTLS or PHTLS or ATLS or equivalent curriculum
 - 3. A registered nurse currently licensed in the State of California who meets the qualifications of an authorized registered nurse as defined in the Health and Safety Code, Chapter 2, Section 1797.56 and who is current in the following:
 - a. ACLS and PALS or equivalent curriculum; and
 - b. BTLS or PHTLS or ATLS or equivalent curriculum

-
4. A paramedic currently licensed in the State of California and accredited in Los Angeles County who meets the qualification of an Emergency Medical Technician-Paramedic as defined in the Health and Safety Code, Chapter 2, Section 1797.84 and who is current in the following:
 - a. ACLS and PALS or equivalent curriculum; and
 - b. BTLS or PHTLS or ATLS or equivalent curriculum

 - C. Medical flight crew members shall complete the provider agency's approved Aeromedical Orientation Program which includes, but is not limited to, the following topics:
 1. General patient care in-flight (assessment/treatment/preparation/handling/equipment);
 2. Changes in barometric pressure, decompression sickness, and air embolism;
 3. Changes in partial pressure of oxygen;
 4. Other environmental factors affecting patient care;
 5. Aircraft operational systems relating to patient care;
 6. Day and night flight protocols;
 7. Aircraft emergencies and safety;
 8. Care of patients who require special consideration in the airborne environment;
 9. Extrication devices and rescue operations (rescue aircraft only);
 10. EMS system and communication procedures;
 11. The Los Angeles County prehospital care system, including all applicable policies, procedures and protocols;
 12. Use of onboard medical equipment;
 13. Additional topics specific to the mission statement and scope of practice of the air ambulance provider.

NOTE: Course content may be reduced if documentation of prior training in specific areas is available.

- D. All medical flight crew members shall receive a minimum of eight (8) hours annually of continuing education/staff development specific to aeromedical transportation based on the agency's identified QI needs (approved topics include, but are not limited to, those listed in C. 1-13).

III. Policies and Procedures

- A. Policies shall be established by each prehospital EMS aircraft program which addresses, at a minimum, the following topics:
 - 1. Patient loading and unloading procedures;
 - 2. Refueling procedures with medical transport personnel or patient(s) on board which includes a requirement that at least one medical transport person shall remain with the patient at all times during refueling or stopover;
 - 3. Combative patients;
 - 4. Patient care and transport alternatives in the event that the aircraft must use alternative landing facilities due to deteriorating weather;
 - 5. Response to hazardous materials request or unanticipated contact with hazardous materials;
 - 6. Visual flight rules (VFR) "response" weather minimums;
 - 7. Emergency Procedures.
- B. Each provider agency shall have a Post Incident Accident Plan (PAIP), also known as an Emergency Response Plan (ERP) in place and exercised at minimum, on an annual basis.

IV. Aircraft Specifications/Required Equipment

- A. Air ambulances shall have sufficient space in the patient compartment to accommodate a minimum of one (1) patient and two (2) ALS patient attendants.
 - 1. If more than one patient can be accommodated, there must be written guidelines describing types of patients that can be transported in a two-patient litter configuration if the aircraft does not allow for full access to the second patient.
- B. Sufficient space in the patient compartment for the medical flight crewmembers to access the patient in order to carry out necessary procedures, including childbirth and CPR.
- C. EMS aircraft shall have on board the required medical supplies and equipment as specified in Reference No. 706, ALS EMS Aircraft Inventory.
- D. Sufficient space for all required medical supplies and equipment.
- E. Additional aircraft equipment as specified in the minimum equipment list for the applicable Federal Aviation Regulations (FARs).
- F. EMS aircraft configuration shall ensure that the following requirements are met:

1. For ALS patients, the upper surface of the stretcher is not less than 30 inches from the ceiling of the aircraft or the under surface of another stretcher.
2. Stretchers, equipment and attendant's seats are arranged so as not to block a rapid exit by personnel or patient from the aircraft.
3. Adequate seat belts and tie-downs, which meet FAA standards or equivalent, for all personnel, patient(s), stretchers and equipment to prevent inadvertent movement.
4. A cargo door or entry that allows a stretcher to be loaded without excessive manipulation or rolling patient from side to side.
5. Adequate interior lighting for patient care arranged so that it does not interfere with the pilot's vision.
6. Each crewmember shall be provided with hearing protection and radio headsets for intra-aircraft communication.
7. Hearing protection shall be available for each patient transported and used whenever applicable.
8. Survival gear appropriate to the coverage area and the number of occupants.
9. If appropriately sized helmets are not worn (by all personnel on the aircraft except the patient), the interior modification of the aircraft must be clear of objects/projections or the interior of the aircraft must be padded to protect the head strike envelope of the air medical personnel and patients.

V. Record Keeping

- A. Existing EMS policies and procedures for record keeping including, but not limited to, documentation of patient care, shall be adhered to.
- B. Each designated dispatch center shall maintain an assignment record which contains all EMS aircraft dispatches. The record shall be retained for seven (7) years and shall include at a minimum the following:
 1. Time and date of request and requesting agency;
 2. Incident number and/or EMS sequence number;
 3. EMS incident location;
 4. Time of dispatch and EMS aircraft scene arrival time;
 5. Person receiving the request;

6. Patient destination.

VI. Quality Improvement (QI)

A. At minimum, the QI program shall include: (Refer to Reference No. 620)

1. A statement of QI program goals and objectives.
2. A description of how the QI program is integrated into the organization.
3. A description of those processes used in conducting QI activities, action plans and results.
4. Methods to document those processes used in QI activities.
5. Methods used to retrieve data regarding patient care and outcomes.
6. Description of how the QI program is integrated into the Los Angeles County EMS system.

B. Provider Agency Responsibilities:

1. Implement and maintain a Quality Improvement (QI) Program in conjunction with the assigned base hospitals and receiving hospitals.
2. Evaluate prehospital care performance standards.
3. Designate a representative to participate in the LA County EMS QI program.

C. Records of QI activities shall be maintained by the provider and available for review by the EMS Agency.

VII. Designated Dispatch Center

A. A designated dispatch center is an agency which has been designated by the local EMS agency to coordinate air ambulance or rescue aircraft response to the scene of a medical emergency within the jurisdiction of the Los Angeles County EMS Agency.

B. Agencies dispatching EMS aircraft or auxiliary aircraft to the scene of a medical emergency for the purpose of transporting a patient(s) to medical facilities shall be designated by the Los Angeles County EMS Agency. Dispatch agencies shall be classified as follows:

1. Primary dispatch center – a dispatch center designated as first responder in a jurisdiction area.

-
2. Back-up dispatch center – a dispatch center designated to serve as back-up provider or second-call response when the primary dispatch center requests response.
- C. No EMS or auxiliary EMS aircraft shall respond to an incident without formal dispatch from the designated dispatch center or request from the primary EMS provider agency dispatch center. An EMS aircraft provider receiving a request for service from an agency other than the designated dispatch center or jurisdictional EMS primary dispatch center shall notify the appropriate primary EMS provider agency of the call and shall only respond upon instructions from that agency.
 - D. Each designated primary dispatch center shall establish a back-up list or enter into a mutual aid agreement with another designated responder for the purpose of providing back-up EMS aircraft service when the primary provider agency is unable to respond. The list shall contain approved prehospital EMS aircraft providers.
 - E. If the designated dispatch center has no EMS aircraft available when requested, they shall determine the availability of other EMS aircraft identified in their back-up provider list. Based on availability, the dispatch center shall consider dispatch of a back-up EMS aircraft in an effort to ensure timely delivery of the patient to the most appropriate receiving facility. The dispatcher shall inform the agency requesting service of unavailability or any delay in dispatch of an EMS aircraft and the reason(s) for the delay. If a request for services is refused by a given provider (e.g. weather), the reason for the flight refusal will be conveyed to any subsequent recipient of the request for service.

VIII. Designation Process

- A. The designation process shall include the following:
 1. Completion and submission of the approved EMS Aircraft/Dispatch Center Application (Reference No. 418.1).
 2. Current accreditation by the Commission on Accreditation of Medical Transport Systems (CAMTS) or successful completion of a site review by CAMTS in conjunction with the local EMS Agency and based on the criteria contained herein.
 3. Program evaluation and site visit/inventory inspection.
 4. Written agreement between the EMS aircraft provider and the County of Los Angeles.
 5. For private, non-governmental EMS aircraft provider agencies, must be licensed by the EMS Agency as an air ambulance provider.
- B. Designation is valid for a minimum of three (3) years.

CROSS REFERENCES:

Prehospital Care Manual:

- Reference No. 406, **Authorization for Paramedic Provider Status**
- Reference No. 408, **Advanced Life Support (ALS) Unit Staffing**
- Reference No. 418.1, **EMS Aircraft/Dispatch Center Application**
- Reference No. 514, **Prehospital EMS Aircraft Operations**
- Reference No. 602, **Confidentiality of Patient Information**
- Reference No. 606, **Documentation of Prehospital Care**
- Reference No. 608, **Disposition of Copies of the EMS Report Form**
- Reference No. 610, **Retention of Prehospital Care Records**
- Reference No. 612, **Release of EMS Reports**
- Reference No. 620, **EMS Quality Improvement Program Guidelines**
- Reference No. 706, **ALS EMS Aircraft Inventory**
- Reference No. 806.1 **Procedures Prior to Base Contact (Field Reference)**
- Reference No. 813, **Standing Field Treatment Protocols**

Emergency Medical Services Authority Guideline 144, Pre-hospital EMS Aircraft Guidelines

LOS ANGELES COUNTY
DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES AGENCY
EMS AIRCRAFT PROVIDER/DISPATCH CENTER DESIGNATION

Application* for: primary air ambulance provider
(check all that apply) back-up air ambulance provider
 primary dispatch center
 back-up dispatch center

Date: _____

Agency/Company Name: _____

Name of Applicant/Owner/Officer: _____

Business Address: _____

Business Phone: _____

Contact Person: _____
(Air ambulance operations)

Contact Person Phone: _____

Please submit a narrative description of your air ambulance/dispatch center operations.
*Application shall be submitted on an annual basis no later than January 31.

POLICIES 4.6

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: SUMMARY OF COMMENTS RECEIVED

REFERENCE NO 202.1

Reference No. 506, Trauma Triage

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Principles: 6.	Base Hospital Advisory / 08/13/2014 Provider Advisory / 08/20/2014	Add, "When pediatric and adult trauma patients are transported together in one aircraft, the receiving trauma center shall also be a pediatric trauma center."	Approved as drafted.
Principles: 7.	Base Hospital Advisory / 08/13/2014 Provider Advisory / 08/20/2014	Add, "Patients in blunt traumatic full arrest, not meeting Reference No. 814, should be transported to the most accessible medical facility appropriate to their needs."	Approved as drafted.
Policy 1., C.	Base Hospital Advisory / 08/13/2014 Provider Advisory / 08/20/2014	Add, "Cardiopulmonary arrest with penetrating torso trauma unless based upon the paramedic's thorough assessment is found apneic, pulseless, asystolic, and without pupillary reflexes upon arrival of EMS personnel at the scene."	Approved as drafted.

SUBJECT: **TRAUMA TRIAGE**

PURPOSE: To establish criteria and standards which ensure that patients requiring the care of a trauma center are appropriately triaged and transported.

AUTHORITY: California Code of Regulations, Title 13, Section 1105(c) California Code of Regulations, Title 22, Section 100236 et seq. Health and Safety Code, Div. 2.5, Section 1797 et seq., and 1317.

PRINCIPLES:

1. Trauma patients should be secured and transported from the scene as quickly as possible, consistent with optimal trauma care.
2. An emergency patient should be transported to the most accessible medical facility appropriate to their needs. The base hospital physician's determination in this regard is controlling.
3. Paramedics shall make base hospital contact or Standing Field Treatment Protocol (SFTP) notification for approved provider agencies with the designated trauma center, when it is also a base hospital, on all injured patients who meet Base Contact and Transport Criteria (Prehospital Care Policy, Ref. No. 808), trauma triage criteria and/or guidelines, or if in the paramedic's judgment it is in the patient's best interest to be transported to a trauma center. Contact shall be accomplished in such a way as not to delay transport.
4. Do not delay transport of hypotensive patients with penetrating torso trauma in order to apply spinal immobilization.
5. EMT personnel may immediately transport hypotensive patients with life-threatening, penetrating injuries to the torso to the closest trauma center, not the Most Accessible Receiving (MAR), when the transport time is less than the estimated time of paramedic arrival. The transporting unit should make every effort to contact the receiving trauma center.
6. When pediatric and adult trauma patients are transported together in one aircraft, the receiving trauma center shall also be a pediatric trauma center.
7. Patients in blunt traumatic full arrest, not meeting Reference No. 814, should be transported to the most accessible medical facility appropriate to their needs.

POLICY:

- I. Trauma Criteria – Requires immediate transportation to a designated trauma center

EFFECTIVE DATE: 6-15-87
REVISED: XX-XX-14
SUPERSEDES: 01-23-14

PAGE 1 OF 4

APPROVED: _____
Director, EMS Agency

Medical Director, EMS Agency

Patients who fall into one or more of the following categories are to be transported directly to the designated trauma center, if transport time does not exceed 30 minutes.

- A. Systolic blood pressure less than 90 mmHg, or less than 70 mmHg in infants age less than one year.
- B. Respiratory rate greater than 29 breaths/minute (sustained), less than 10 breaths/minute, less than 20 breaths/minute in infants age less than one year, or requiring ventilatory support
- C. Cardiopulmonary arrest with penetrating torso trauma unless based upon the paramedic's thorough assessment is found apneic, pulseless, asystolic, and without pupillary reflexes upon arrival of EMS personnel at the scene.
- D. All penetrating injuries to head, neck, torso, and extremities proximal to the elbow or knee
- E. Blunt head injury associated with a suspected skull fracture, altered level of consciousness (GCS less than or equal to 14), seizures, unequal pupils, or focal neurological deficit
- F. Injury to the spinal column associated with acute sensory or motor deficit
- G. Blunt injury to chest with unstable chest wall (flail chest)
- H. Diffuse abdominal tenderness
- I. Suspected pelvic fracture (excluding isolated hip fracture from a ground level fall)
- J. Extremity injuries with:
 - i. Neurological/vascular compromise and/or crushed, degloved, or mangled extremity
 - ii. Amputation proximal to the wrist or ankle
 - iii. Fractures of two or more proximal (humerus/femur) long-bones
- K. Falls:
 - i. Adult patients from heights greater than 15 feet
 - ii. Pediatric patients from heights greater than 10 feet, or greater than 3 times the height of the child
- L. Passenger space intrusion of greater than 12 inches into an occupied passenger space
- M. Ejected from vehicles (partial or complete)
- N. Auto versus pedestrian/bicyclist/motorcyclist thrown, run over, or with significant (greater than 20 mph) impact
- O. Unenclosed transport crash with significant (greater than 20 mph) impact

- II. Trauma Guidelines – Mechanism of injury and patient history are the most effective methods of selecting critically injured patients before unstable vital signs develop. Paramedics and base hospital personnel should consider mechanism of injury and patient history when determining patient destination. At the discretion of the base hospital or approved SFTP provider agency, transportation to a trauma center is advisable for:
- A. Passenger space intrusion of greater than 18 inches into any unoccupied passenger space
 - B. Automobile versus pedestrian/bicyclist/motorcyclist (impact equal to or less than 20 mph)
 - C. Injured victims of vehicular crashes in which a fatality occurred in the same vehicle
 - D. Patients requiring extrication
 - D. Vehicle telemetry data consistent with high risk of injury
 - E. Injured patients (excluding isolated minor extremity injuries):
 - i. on anticoagulation therapy other than aspirin-only
 - ii. with bleeding disorders
- III. Special Considerations – Consider transporting injured patients with the following to a trauma center:
- A. Adults age greater than 55 years
 - B. Systolic blood pressure less than 110 mmHg may represent shock after age 65 years
 - C. Pregnancy greater than 20 weeks gestation
 - D. Prehospital judgment
- IV. Extremis Patients - Requires immediate transportation to the MAR:
- A. Patients with an obstructed airway
 - B. Patients, as determined by the base hospital personnel, whose lives would be jeopardized by transportation to any destination but the MAR
- V. When, for whatever reason, base hospital contact cannot be made, the destination decision for injured patients will be made by paramedics using the principles set forth above.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 501, **Hospital Directory**

Ref. No. 502, **Patient Destination**

Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**

Ref. No. 504, **Trauma Patient Destination**

Ref. No. 808, **Base Hospital Contact and Transport Criteria**

Ref. No. 814, **Determination/Pronouncement of Death in the Field**

PRINCIPLES:

1. The Los Angeles County EMS Agency is responsible for the integration of EMS aircraft into the Los Angeles County EMS patient transport system and for the development of policies and procedures related to the integration of this specialized resource. EMS aircraft operating in Los Angeles County must be classified and authorized by the EMS Agency in order to provide prehospital patient transport.
2. EMS aircraft providers (excluding agencies of the federal government) who provide or make available prehospital air transport or medical personnel, either directly or indirectly, or any hospital where an EMS aircraft is based, housed, or stationed permanently or temporarily, shall adhere to all federal, state, and local statutes, ordinances, policies, and procedures related to EMS aircraft operations, including qualifications of flight crews and aircraft maintenance.
3. Availability and appropriateness of EMS aircraft transport shall be determined by the primary EMS provider agency on scene. This will be based on the patient's status, ground ambulance response time, and proximity to a receiving facility staffed and equipped to meet the needs of the patient(s), i.e., trauma centers, pediatric trauma center, etc. versus the most accessible receiving facility (MAR).
4. The base hospital directing the patient's care shall be the medical authority in determining patient destination and treatment in accordance with all applicable prehospital care policies.
5. No EMS aircraft shall respond to an incident without formal dispatch from a designated dispatch center or request from the primary provider agency responsible for the area in which the incident has occurred.
6. The primary provider agency requesting EMS aircraft response shall assume medical management responsibility at the scene, and shall be responsible for proper protection of the emergency landing site during its use in the event that a licensed heliport is not available. This shall include, but not be limited to, fire protection, rescue services, exclusion of extraneous individuals, control of duties performed in the immediate vicinity of the aircraft (special attention will be paid to the main rotor, the tail rotor, and the effects of rotor downwash), and patient protection during landing.
7. The authority for safety of the EMS aircraft and persons associated with the EMS aircraft shall rest with the Pilot In Command (PIC). This shall include the supervision of those persons directly involved in loading/unloading patients and/or supplies.

POLICY:**I. Dispatch Criteria**

Availability and appropriateness of EMS aircraft transport shall be determined by the primary provider agency on scene with regard to, but not limited to, the following:

- A. The determination of ground versus air transport should be based on the time of day, incident location, weather conditions, traffic obstructions, etc.
- B. An EMS aircraft should be considered for dispatch to an incident any time ground response will result in an extended estimated time of arrival, and/or incident location is inaccessible by ground ambulance.

- C. If aeromedical transport is indicated and the requested/most accessible EMS aircraft is unavailable, or has declined the request due to conditions not conducive to air transport, the next most accessible EMS aircraft provider should be requested, until all resources have been exhausted. If a request for services is refused by a particular provider (e.g. weather), the reason for the flight refusal will be conveyed to any subsequent recipient of the request for service.
 - D. Patients meeting trauma center criteria should be transported by EMS aircraft when a trauma center cannot be accessed by ground within 30 minutes (Reference No. 506, Trauma Triage).
 - E. Patients meeting Pediatric Medical Center (PMC) criteria may be transported by EMS aircraft when a PMC cannot be accessed by ground within the timeframe specified in Reference No. 510, Pediatric Patient Destination. The decision to transport these patients via EMS aircraft should be made in consultation with the base hospital.
 - F. For patients requiring ALS level care who do not meet specialty center (i.e., trauma center, PMC, or perinatal center) criteria or guidelines and whose condition is deteriorating and transport to a basic 9-1-1 receiving center is extended, transport by EMS aircraft may be considered.
 - G. The designated dispatch center or primary provider agency requesting/dispatching EMS aircraft responses shall notify the following facilities/agencies as early as possible, and prior to patient/EMS aircraft arrival. Examples of these facilities/agencies include, but are not limited to the following:
 - 1. Local fire department
 - 2. Local law enforcement for scene jurisdiction
 - 3. Base hospital, if applicable, in accordance with established policies and procedures.
 - 4. Receiving hospital (when possible, the receiving hospital should be notified by both the EMS Aircraft and the base hospital handling the call).
 - 5. Medical Alert Center
 - H. Dispatch of EMS aircraft may not be appropriate under certain circumstances and patients may require transport to the most accessible 9-1-1 receiving facility (MAR) staffed and equipped to handle the patient in compliance with State and local EMS policies and procedures.
 - 1. The patient has an uncontrollable life-threatening situation (e.g., obstructed airway).
 - 2. There are conditions not conducive to air transport such as inadequate landing site, poor weather, etc.
 - 3. Air transport is not immediately available when the patient is ready for transport and the risks of delaying transport outweigh the risks of transporting by ground.
- II. Cancellation

When an EMS aircraft response has been requested, the decision to cancel the EMS aircraft may be made by one or more of the following, as appropriate for the incident:

- A. Primary provider EMS personnel
- B. Incident commander
- C. PIC of the EMS aircraft
- D. Requesting personnel and/or organization
- E. Base hospital physician

NOTE: The designated dispatch center or primary provider agency managing the request for an EMS aircraft shall notify all affected parties of the cancellation of an EMS aircraft.

III. Patient Destination/Landing Sites

- A. The base hospital directing the patient's care shall determine patient destination in accordance with the applicable patient destination policies, provided the receiving facility has a State approved and licensed heliport or designated landing site. Hospital diversion status is also a consideration in determining patient destination. The base hospital shall contact the receiving facility and relay all pertinent information concerning the patient's condition.
- B. If base hospital contact cannot be established or maintained, the decision for patient destination shall be made by the highest medical authority on scene. Hospital diversion status may be obtained from the Medical Alert Center (MAC) or via the ReddiNet system. Pertinent patient information and ETA should be relayed directly to the receiving hospital, through the MAC or the designated dispatch center.
- C. All applicable destination policies will be followed for patients treated under Reference No. 806.1, Procedures Prior to Base Contact, or SFTPs. Hospital diversion status and availability of a State approved and licensed heliport or designated landing site are factors that need to be considered. Paramedics shall contact the receiving facility directly and relay all required information concerning the patient's condition. If the aircraft is unable to communicate with the receiving facility (terrain related), all efforts should be made to communicate with the receiving facility via the base hospital, dispatch center, or the MAC.
- D. All patient destinations, with respect to safety factors, shall be approved by the PIC.
- E. In all situations where temporary emergency landing sites are used, the PIC of each EMS aircraft will exercise primary authority and responsibility for the safe operation of the aircraft. If a hospital with a State approved and licensed heliport or designated landing site is in proximity to an incident requiring EMS aircraft transport, such heliport or landing site may be utilized for continuation of the 9-1-1 call and is not in violation of the Emergency Medical Treatment and Active Labor Act (EMTALA).
- F. When pediatric and adult trauma patients are transported together in one aircraft, the receiving trauma center shall also be a pediatric trauma center.

IV. Communication/Record Keeping

- A. EMS aircraft shall have the capability of communicating with each of the following:
 - 1. Designated dispatch center
 - 2. EMS ground units at scene of an emergency
 - 3. Designated base hospitals
 - 4. Receiving hospitals
 - 5. Other appropriate facilities or agencies
 - 6. Required FAA facilities

NOTE: Whenever possible, direct communication should be established.

- B. All EMS aircraft shall utilize appropriate radio frequencies for dispatch, routing and coordination of flights. This excludes use of Med 1-8 and Hospital Emergency Administrative Radio (V MED 28) for these purposes.
 - C. Each EMS aircraft shall establish base hospital contact with their assigned base hospital or the appropriate area base hospital pursuant to Reference No. 808, Base Hospital Contact and Transport Criteria unless the call is a prearranged, specialty center, interfacility transfer.
 - D. When receiving a patient(s) from ground units, the medical flight crew shall ensure that, if applicable, base hospital contact has been made and/or continued. Such contact shall not unnecessarily delay patient transport.
 - E. In the event voice communication cannot be established or maintained with the base hospital, paramedics shall utilize Reference No. 806.1, Procedures Prior to Base Contact, or SFTPs if an approved SFTP provider.
 - F. All applicable prehospital care policies and procedures related to record keeping shall apply to EMS aircraft operations.
- V. Medical Control
- A. All EMS policies and procedures for medical control and patient destination shall apply to the medical flight crew.
 - B. In situations where the medical flight crew is less medically qualified than the ground personnel from whom they receive patients, the medical flight crew may assume patient care responsibility only in accordance with policies and procedures established by the EMS Agency.
 - C. Medical flight crewmembers who have an expanded scope of practice (Physicians/RNs) beyond Reference No. 803, Paramedic Scope of Practice, may only utilize specific treatments/procedures for which they are licensed, trained and qualified. In such cases, notification to the receiving facility shall be made and base hospital medical direction is not required.
 - D. If a physician is aboard an EMS aircraft, under no circumstances will the presence of said physician endorse the violation of recognized limits of scope of practice of any EMT-I, paramedic, or RN aboard the aircraft.
- VI. Quality Improvement

- A. The EMS Agency, base hospitals, trauma centers, and provider agencies shall conduct regular review of all trauma related EMS aircraft responses.
- B. Documentation on the EMS Report Form and Base Hospital Form should include an explanation for the use of an air ambulance (i.e., mountain rescue).

CROSS REFERENCES:Prehospital Care Manual:

- Reference No. 502, **Patient Destination**
- Reference No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
- Reference No. 504, **Trauma Patient Destination**
- Reference No. 506, **Trauma Triage**
- Reference No. 508, **Sexual Assault Patient Destination**
- Reference No. 510, **Pediatric Patient Destination**
- Reference No. 511, **Perinatal Patient Destination**
- Reference No. 512, **Burn Patient Destination**
- Reference No. 518, **Decompression Emergencies/Patient Destination**
- Reference No. 519, **Management of Multiple Casualty Incidents**
- Reference No. 520, **Transport of Patients from Catalina Island**
- Reference No. 606, **Documentation of Prehospital Care**
- Reference No. 802, **Emergency Medical Technician Scope of Practice**
- Reference No. 803, **Paramedic Scope of Practice**
- Reference No. 806.1 **Procedures Prior to Base Contact (Field Reference)**
- Reference No. 808, **Base Hospital Contact and Transport Criteria**
- Reference No. 813, **Standing Field Treatment Protocols**

POLICIES 4.8

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: SUMMARY OF COMMENTS RECEIVED

REFERENCE NO 202.1

Reference No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Entire Policy	PAAC 10/15/14	Accepted and approved as is, no changes	

SUBJECT: **SUPPLY AND RESUPPLY OF DESIGNATED
EMS PROVIDER UNITS/VEHICLES**

(PARAMEDIC)
REFERENCE NO. 701

PURPOSE: To provide a policy for 9-1-1 provider agencies to procure, store and distribute medical supplies and pharmaceuticals identified in the ALS Unit Inventory that require specific physician authorization.

AUTHORITY: California Health and Safety Code, Division 10, California Uniform Controlled Substances Act; and Division 2.5, Chapter 5, Section 1798.
California Code of Regulations, Title 22, Chapter 4, Article 6, Section 100168

DEFINITION:

Restricted Drugs and Devices: Drugs and devices bearing the legend, "Caution, federal law prohibits dispensing without prescription," or "Federal Law restricts this device to sale by or the order of a physician," or words of similar import.

POLICY:

I. Responsibilities of Provider Agencies

A. Each provider agency shall have a mechanism to procure, store and distribute its own restricted drugs and devices under the license and supervision of a physician who meets one of the following criteria:

1. The Medical Director of the provider agency. Medical Director must meet the requirements specified in Ref. No. 411, Provider Agency Medical Director.
2. The Medical Director of the EMS Agency.
3. The Base Hospital Medical Director of the provider agency's assigned base hospital.
4. A drug authorizing physician who is licensed in the State of California and meets the criteria outlined in Ref. No. 410, Drug Authorizing Physician for Provider Agencies.

NOTE: Regardless of option selected, the provider agency shall furnish the EMS Agency with written concurrence from the respective physician that they will assume responsibility for providing medical authorization for procuring restricted drugs and devices.

EFFECTIVE DATE: 06-08-76
REVISED: 12-01-14
SUPERSEDES: 2-15-10

PAGE 1 OF 3

APPROVED: _____

Director, EMS Agency

Medical Director, EMS Agency

B. Mechanisms of procurement may include the following:

1. Procurement of restricted drugs and devices through a County-sponsored or other group buying arrangement, if feasible.
2. Procurement of restricted drugs and devices from a hospital that determines it has the legal authority to resell pharmaceuticals and supplies to a provider agency.
3. Procurement of restricted drugs and devices through another legally authorized source, including but not limited to, a pharmaceutical distributor or wholesaler.

C. Each provider agency shall have policies and procedures in place for the procurement, transport, storage, distribution and disposal of restricted drugs and devices. These policies shall be reviewed by the local EMS Agency and shall include, but are not limited to, the following:

1. Identification (by title) of individuals responsible for procurement and distribution.
2. A determination of reasonable quantities of supplies and pharmaceuticals that must be maintained to resupply ALS units between deliveries by distributor.
3. Maintenance of copies of all drug orders, invoices, and logs associated with restricted drugs and devices for a minimum of three years.
4. Procedures for completing a monthly inventory, which includes:
 - a. Ensuring medications are stored in original packaging;
 - b. Checking medications for expiration dates, rotating stock for use prior to expiration, and exchanging for current medications.
 - c. Properly disposing of expired medications that cannot be exchanged.
 - d. Accounting for restricted drugs and devices in stock and/or distributed to ALS units and other transport units.
 - e. Returning medications to the pharmaceutical distributor if notified of a recall.
5. Storage of drugs (other than those carried on the ALS unit itself) that complies with the following:
 - a. Drugs must be stored in a locked cabinet or storage area.
 - b. Drugs may not be stored on the floor. (Storage of drugs on pallets is acceptable.)

- c. Antiseptics and disinfectants must be stored separately from internal and injectable medications.
 - d. Flammable substances, e.g., alcohol, must be stored in accordance with local fire codes.
 - e. Storage area is maintained within a temperature range that will maintain the integrity, stability and effectiveness of drugs.
6. A mechanism for procuring, storing, distributing and accounting for controlled drugs is consistent with the requirements outlined in Ref. No. 702, Controlled Drugs Carried on ALS Units.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 410, **Drug Authorizing Physician for Provider Agencies**

Ref. No. 411, **Provider Agency Medical Advisor**

Ref. No. 702, **Controlled Drugs Carried on ALS Units**

Ref. No. 703, **ALS Unit Inventory**

Ref. No. 704, **Assessment Unit Inventory**

POLICIES 4.9

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: SUMMARY OF COMMENTS RECEIVED

REFERENCE NO 202.1

Reference No. 806.1, Procedures Prior to Base Contact

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Entire Policy	BHAC 10/08/14	Requested to have subheadings bolded & underlined for easier reading	Changes made
Entire Policy	PAAC 10/16/14	Accepted and approved as is	

COUNTY OF LOS ANGELES – EMS AGENCY
PROCEDURES PRIOR TO BASE CONTACT - REFERENCE NO. 806.1

Prior to base hospital contact, paramedics may utilize the following treatment protocols:

GENERAL ALS	ALTERED LOC
<ol style="list-style-type: none"> Basic airway/O₂ prn BVM & advanced airway prn Cardiac monitor/document rhythm prn Venous access prn If indicated, blood glucose test; if <60mg/dl administer: Dextrose 50% 50ml slow IVP Pediatric: 1month-<2yrs of age: 25% 2ml/kg slow IVP ≥2yrs age: 50% 1ml/kg slow IVP up to 50 ml Pediatric resuscitation tape prn Ondansetron: may give 4mg IV, IM or ODT one time for nausea/vomiting/morphine administration 	<ol style="list-style-type: none"> General ALS If blood glucose <60mg/dl and unable to obtain IV, Glucagon 1mg IM If narcotic overdose, Naloxone 2mg IM/IN prior to venous access or advanced airway Adult: 0.8-2mg IVP, titrate to adequate RR/TV or 2mg IM/IN Pediatric: 0.1mg/kg IV/IM/IN
RESPIRATORY DISTRESS	SHOCK
<ol style="list-style-type: none"> General ALS ARREST/HYPOVENTILATION (RR< 8/MIN): If suspected narcotic OD with hypoventilation, Naloxone 2mg IM/IN prior to venous access or advanced airway Adult: 0.8-2mg IVP, titrate to adequate RR/TV or 2mg IM/IN Pediatric: 0.1mg/kg IV/IM/IN May repeat PRN 	<ol style="list-style-type: none"> General ALS Normal saline fluid challenge. If basilar rales or cardiogenic shock suspected, reduce rate to TKO Adult: 10ml/kg, assess lung sounds frequently Pediatric: 20ml/kg Perform needle thoracostomy enroute if suspected tension pneumothorax with SBP<80mmHg
BRONCHOSPASM/WHEEZING	ANAPHYLAXIS
<ol style="list-style-type: none"> Albuterol Adult: 5mg via hand-held nebulizer Pediatric: age <1yr=2.5mg age ≥1yr=5.0mg May repeat one time prn 	<ol style="list-style-type: none"> General ALS ADEQUATE PERFUSION Epinephrine: Adult: 0.3mg (1:1,000) IM Pediatric: 0.01mg/kg (1:1,000) IM, maximum single dose 0.3mg for weight 30kg or greater Albuterol, if wheezing: Adult: 5mg via hand-held nebulizer Pediatric: age <1yr=2.5mg age ≥1yr=5.0mg
BASILAR RALES – CARDIAC ORIGIN (ADULTS ONLY)	POOR PERFUSION
<ol style="list-style-type: none"> Nitroglycerin (NTG) SL: SBP ≥ 100=0.4mg (1 puff or 1 tablet) SBP ≥ 150=0.8mg (2 puffs or 2 tablets) SBP ≥ 200=1.2mg (3 puffs or 3 tablets) May repeat two times in 3-5min based on repeat BP Albuterol 5mg via hand-held nebulizer if wheezing Consider CPAP if available; max pressure 10cmH₂O 	<ol style="list-style-type: none"> Epinephrine Adult: 0.1mg (1:10,000) slow IVP. If unable to obtain IV, 0.5mg (1:1,000) IM Pediatric: 0.01mg/kg (1:1,000) IM, maximum single dose 0.3mg for weight 30kg or greater Normal saline fluid challenge if lungs are clear. Adult: 10ml/kg, assess lung sounds frequently Pediatric: 20ml/kg
CHEST PAIN (Adult)	PAIN MANAGEMENT
<ol style="list-style-type: none"> General ALS 12-lead ECG for suspected acute cardiac event Transport to MAR if ECG=no MI Transport to SRC if ECG=suspected acute MI NTG 0.4mg SL, may repeat 2 times every 3-5min if SBP>100mmHg Aspirin 162-325mg, chewable 	<ol style="list-style-type: none"> General ALS ISOLATED EXTREMITY INJURY/BURN Traction/splints/dressings prn Morphine for moderate to severe pain 2-4mg slow IVP, titrate to pain relief; MR one time Pediatric: 0.1mg/kg slow IVP; do not repeat OR Fentanyl for moderate to severe pain 50mcg slow IVP, titrate to pain relief; do not repeat Pediatric: 1mcg/kg slow IVP; do not repeat pediatric dose; maximum
ACTIVE SEIZURE	CRUSH INJURY
<ol style="list-style-type: none"> General ALS Midazolam** Adult: 2-5mg slow IVP, titrate to control seizure activity; if unable to establish IV, 5mg IN/IM** Pediatric: Up to 0.1mg/kg IVP titrate to control seizure activity; if unable to establish IV, 0.1mg/kg IM/IN May repeat one time in 5min. Maximum adult dose 10mg all routes, max pediatric dose 5mg all routes <p>**Controlled substances are NOT in the Assessment Unit Inventory</p>	<ol style="list-style-type: none"> Morphine 2-12mg slow IVP, titrate to pain relief; maximum total adult dose 20mg Pediatric: 0.1mg/kg slow IVP; do not repeat pediatric dose; maximum total dose 4mg OR Fentanyl see above for dosing.

Base hospital contact shall be made following each of the treatment protocols. If communication cannot be established, base contact shall be made with a full patient report prior to leaving the receiving facility.

SYMPTOMATIC BRADYCARDIA	CARDIOPULMONARY ARREST
<p>1. General ALS</p> <p>ADULT: HR < 40/MINUTE AND SBP < 80MMHG:</p> <p>2. Atropine 0.5mg IVP</p> <p>3. If suspected hyperkalemia, Albuterol 5mg via continuous mask nebulization two times</p> <p>4. If no improvement, TCP; follow department guidelines</p> <p>PEDIATRIC: HR < 60/MINUTE:</p> <p>2. Assist respirations with BVM prn Rescue airway: King LTs-D if ≥ 12 yrs and 4ft. tall</p> <p>3. Advanced airway prn.</p> <p>4. CPR if ≤ 8 yrs and HR < 60bpm after effective ventilations</p>	<p>Non-Traumatic</p> <p>1. BCLS/cardiac monitor</p> <p>IF V-FIB/PULSELESS V-TACH:</p> <p>Unwitnessed: 2min CPR at 100/min or greater then defibrillate, minimize interruptions to CPR and immediately resume CPR for 2min</p> <p>Witnessed: CPR while charging monitor; defibrillate</p> <p>2. Defibrillation</p> <p>Adult: biphasic, 120-200J* monophasic 360J</p> <p>Pediatric: 2J/kg monophasic or biphasic*</p> <p>3. Venous access; if unable, place IO* If hypovolemia, NS fluid challenge:</p> <p>Adult: 10ml/kg rapid IV/IO*</p> <p>Pediatric: 20ml/kg IV/IO*</p> <p>4. Defibrillation</p> <p>Adult: biphasic* monophasic 360J</p> <p>Pediatric: 4J/kg monophasic or biphasic*</p> <p>5. Epinephrine (1:10,000) (indicated for all pulseless rhythms)</p> <p>Adult: 1mg IV/IO*</p> <p>Pediatric: 0.01mg/kg IV/IO*</p> <p>6. If no conversion, defibrillate and immediately resume CPR for 2min</p> <p>Adult: biphasic* monophasic 360J</p> <p>Pediatric: 4 J/kg monophasic or biphasic*</p> <p>7. If no conversion, immediately resume CPR for 2min</p>
<p>SUPRAVENTRICULAR TACHYCARDIA NARROW QRS ≥ 150bpm</p>	<p>ASYSTOLE OR PEA</p>
<p>1. General ALS</p> <p>ADEQUATE PERFUSION</p> <p>Adult:</p> <p>2. Valsalva maneuver</p> <p>3. If no conversion, Adenosine 6mg rapid IVP immediately followed by a 10-20ml NS bolus</p> <p>4. If no conversion, Adenosine 12mg rapid IVP immediately followed by a 10-20ml NS bolus</p> <p>Pediatric (infant HR > 220bpm, child HR > 180bpm):</p> <p>5. Rapid transport. Monitor closely.</p> <p>POOR PERFUSION</p> <p>Adult:</p> <p>2. If IV access, Adenosine 12mg rapid IVP immediately followed by a 10-20ml rapid IV flush. If no conversion, may repeat one time in 1-2min</p> <p>3. Synchronized cardioversion* May repeat one time.</p> <p>Pediatric:</p> <p>4. NS fluid challenge 20ml/kg IV</p>	<p>2. Venous access, if unable, place IO*</p> <p>3. Adult: Epinephrine (1:10,000) 1mg IV or IO*</p> <p>Pediatric: 0.01mg/kg IV/IO*</p> <p>4. If narrow complex and HR > 60bpm: NS fluid challenge 10ml/kg IV or IO* in 250cc increments</p> <p>5. Advanced airway prn</p>
<p>SUPRAVENTRICULAR TACHYCARDIA WIDE QRS</p>	<p>Traumatic</p>
<p>1. General ALS</p> <p>ADEQUATE PERFUSION > 150BPM</p> <p>Adult:</p> <p>2. Adenosine 6mg rapid IVP immediately followed by a 10-20ml NS bolus</p> <p>3. If no conversion, Adenosine 12mg rapid IVP immediately followed by a 10-20ml NS bolus.</p> <p>Pediatric</p> <p>4. Rapid transport. Monitor closely.</p> <p>POOR PERFUSION</p> <p>Adult:</p> <p>2. Synchronized cardioversion, may repeat one time*</p> <p>Pediatric:</p> <p>3. Synchronized cardioversion 0.5-1J/kg mono- or biphasic</p> <p>4. If no conversion, synchronized cardioversion 2J/kg</p> <p>5. Rapid transport</p> <p>*Adult biphasic: administer according to departmental or manufacturer's recommendations. If unknown, use highest setting.</p>	<p>1. BCLS - do not delay transport for treatment, maintain spinal immobilization if indicated</p> <p>2. Cardiac monitor</p> <p>If V-Fib/Pulseless V-Tach:</p> <p>3. Defibrillation</p> <p>Adult: biphasic 120-200J* monophasic 360J</p> <p>Pediatric: 2J/kg monophasic or biphasic</p> <p>4. Perform needle thoracostomy enroute if suspected tension pneumothorax</p> <p>5. Advanced airway prn.</p> <p>6. Venous access en route. If unable to establish IV, place IO*</p> <p>Adult: 10ml/kg rapid IV/IO*</p> <p>Pediatric: 20ml/kg IV/IO* * If IO is available</p>
	<p>HAZARDOUS MATERIAL</p>
	<p>1. General ALS</p> <p>2. If base contact cannot be established, refer to Ref. No. 1225, Nerve Agent Exposure, and Ref. No. 1235, Radiological Exposure.</p>

Base hospital contact shall be made following each treatment protocol. If communication cannot be established, base contact shall be made with a full patient report prior to leaving the facility.



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

**PROVIDER AGENCY DRUG AUTHORIZING PHYSICIAN
CONFIRMATION OF AGREEMENT TO PURCHASE
DRUGS AND MEDICAL SUPPLIES**

I have agreed to assume responsibility for _____ purchase of drugs, medical devices, and controlled drugs under my medical license and DEA registration number.

Current contact information is:

(physician printed name)

(address)

(business telephone and cellular phone)

(e-mail address)

California Physician's & Surgeon's License Number

Signature and Date

Please return to:

Department of Health Services
Emergency Medical Services Agency
10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670
Attn: Provider Agency Program Manager

POLICIES 4.11 (Info only)

SUBJECT: **AMBULANCE VEHICLE ESSENTIAL
MEDICAL EQUIPMENT**

REFERENCE NO. 451.1a

Failure to maintain the following medical equipment and medical supplies on an ambulance vehicle that is in service shall result in a notice of violation being issued to the ambulance operator:

Basic Life Support (BLS) Unit

MINIMUM INVENTORY	QUANTITY
Ankle and wrist restraints <ul style="list-style-type: none"> • If soft ties are used, they should be at least three (3) inches wide (before tying) to maintain a two (2) inch width while in use 	1 set
Bag-valve device with O ₂ inlet and reservoir: <ul style="list-style-type: none"> • Adult • Pediatric 	1 each
Bag-valve mask: <ul style="list-style-type: none"> • Large • Medium • Small adult/child • Toddler • Infant • Neonate 	1 each
Blood pressure manometer, cuff and stethoscope: <ul style="list-style-type: none"> • Thigh • Adult • Child • Infant 	1 each
Cervical Collars, rigid: <ul style="list-style-type: none"> • Adult • Child • Infant 	2 each
Linen Supplies	1 set
Oropharyngeal airways: <ul style="list-style-type: none"> • Two adult • Two children • One infant • One newborn 	6
Oxygen cannulas: <ul style="list-style-type: none"> • Adult • Child 	1 each

EFFECTIVE: 8-1-12
REVISED: 12-1-14
SUPERSEDES: 9-1-13

MINIMUM INVENTORY	QUANTITY
Oxygen masks, transparent: <ul style="list-style-type: none"> • Adult • Child • Infant 	1 each
Oxygen, portable <ul style="list-style-type: none"> • (USP) regulator with oxygen supply that at maximum capacity is sufficient to provide a patient with not less than 10 liters per minute for 45 minutes (equivalent to an “D” cylinder) 	2
Oxygen, vehicle (house) <ul style="list-style-type: none"> • (USP) regulator with oxygen supply that at maximum capacity is sufficient to provide a patient with not less than 10 liters per minute for a minimum of 3 hours (equivalent to an “M” cylinder) 	1
Personal Protective Equipment (Body Substance Isolation Equipment): <ul style="list-style-type: none"> • Mask • Gown • Eye protection 	2 each
Spine boards, rigid, approximately 14 inches in width: <ul style="list-style-type: none"> • One approximately 72 inches in length with straps for immobilization of suspected spinal or back injuries 	1
Stretchers: <ul style="list-style-type: none"> • Stretcher with wheels and the following: <ul style="list-style-type: none"> ○ mattress should be covered with impervious plastic material or the equivalent ○ have the capability to elevate both the head and foot ○ straps to secure the patient to the stretcher and a means of securing the stretcher in the vehicle ○ be adjustable to four different levels 	1
Suction equipment, portable, capable of at least: <ul style="list-style-type: none"> • a negative pressure equivalent to 300 mm of mercury • 30 liter per minute air flow rate for 30 minutes of operation 	1
Suction equipment, vehicle (house), capable of at least: <ul style="list-style-type: none"> • a negative pressure equivalent to 300 mm of mercury • 30 liter per minute air flow rate for 30 minutes of operation 	1
Suction tubing: <ul style="list-style-type: none"> • Non-collapsible, plastic, semi-rigid, whistle tipped, finger controlled type is preferred • Flexible catheters for tracheostomy suctioning (8Fr.-12Fr.) 	1 each
Tourniquets (commercial, for control of bleeding)	2

PERSONAL PROTECTION EQUIPMENT (PPE)	QUANTITY
Gloves, work (multiple use, leather)	2 pairs
Hearing Protection (includes foam ear plugs)	2 sets
Jacket, EMS, with reflective stripes	2
Rescue Helmet	2
Respiratory protection mask (N95) and general purpose mask	2 each
Safety vest meeting ANSI standards or equivalent	2

ADVANCED LIFE SUPPORT (ALS) UNIT

An ALS unit must maintain all of the medical equipment and medical supplies listed for a BLS unit, plus the following additional items:

MINIMUM INVENTORY MEDICATIONS	QUANTITY
Albuterol (pre-mixed with NS)	20 mgs
Adenosine	24 mgs
Amiodarone	900 mgs
Aspirin (chewable 81 mg)	648 mgs
Atropine sulfate (1mg/ml or 0.4mg/ml)	4 mgs
Atropine sulfate (1mg/10ml)	6 mgs
Calcium chloride	1 gm
Dextrose 50%	150 mls
Dextrose solution 100 gm (glucose paste may be substituted)	1
Dopamine***	400 mgs
Epinephrine (1:1,000)	2 mgs
Epinephrine (1:10,000)	10 mgs

MINIMUM INVENTORY MEDICATIONS	QUANTITY
Glucagon	1 mg
Midazolam*	20 mgs
Morphine sulfate **	32 mgs
Naloxone	4 mgs
Normal saline (for injection)	2 vials
Nitroglycerin spray	1
Sodium bicarbonate	50 mls

*Midazolam carried on ALS Unit may not exceed 40 mgs.

**Morphine sulfate carried on ALS Unit may not exceed 60 mgs.

***Optional medication with EMS Agency authorization.

MINIMUM INVENTORY INTRAVENOUS FLUIDS	QUANTITY
1000 ml normal saline	8
250 or 500 ml normal saline	2

MINIMUM INVENTORY SUPPLIES	QUANTITY
Airways – Nasopharyngeal <ul style="list-style-type: none"> • Large (34-36) • Medium (26-28) • Small (20-22) 	1 each
Airways – Oropharyngeal <ul style="list-style-type: none"> • Large (Adult) • Medium (Adult) 	1 each
Burn pack or burn sheets	1
Contaminated needle container	1
Defibrillator with oscilloscope	1
Defibrillator electrodes (including pediatric) or paste	2

MINIMUM INVENTORY SUPPLIES	QUANTITY
Double lumen esophageal tracheal airway (ETC)*** <ul style="list-style-type: none"> • Small adult • Adult 	1 each
ECG electrodes (adult and pediatric)	6 each
Endotracheal tubes with stylettes <ul style="list-style-type: none"> • Sizes 6.0-8.0 	2 each
End Tidal CO ₂ detector and aspirator (adult)	1 each
Gloves (sterile)	2 pairs
Gloves (unsterile)	1 box
Glucometer with strips	1
Hand-held nebulizer pack	2
Hemostats, padded	1
Intravenous catheters (14G-22G)	5 each
Intravenous tubing <ul style="list-style-type: none"> • Microdrip • Macrodrip 	6 each
King LTS-D (Disposable Supraglottic Airway device) <ul style="list-style-type: none"> • Small adult (size 3) • Adult (size 4) • Large Adult (size 5) 	1 each
Lancets, automatic retractable	5
Laryngoscope Handle (adult)	1
Laryngoscope blades <ul style="list-style-type: none"> • Adult (curved and straight) • Pediatric (Miller #1 and #2) 	1 each
Magill Forceps (adult and pediatric)	1 each
Mucosal Atomization Device (MAD)	2
Normal saline for irrigation	1 bottle
Needle thoracostomy kit or 14 G 2" angiocath	2

MINIMUM INVENTORY SUPPLIES	QUANTITY
Pediatric resuscitation tape	1
Procedures Prior to Base Contact Field Reference No. 806.1	1
Pulse Oximeter	1
Saline locks	4
Syringes (1 ml – 60 ml)	Assorted
Tube introducer	2
Vaseline gauze	2

CRITICAL CARE TRANSPORT (CCT) UNIT

A CCT unit must maintain all of the medical equipment and medical supplies listed for a BLS unit, plus the following additional items:

MINIMUM INVENTORY MEDICATIONS	QUANTITY
Albuterol (pre-mixed with NS)	20 mgs
Adenosine	24 mgs
Amiodarone	450 mgs
Aspirin (chewable 80 mg)	648 mgs
Atropine sulfate (1mg/10ml)	6 mgs
Calcium chloride	1 gm
Dextrose 50%	100 ml
Dextrose solution 100 gm (glucose paste may be substituted)	1
Dopamine (premix or vials)	800 mgs
Epinephrine (1:1,000)	1 mg

MINIMUM INVENTORY MEDICATIONS	QUANTITY
Epinephrine (1:10,000)	4 mgs
Furosemide	100 mgs
Lidocaine (1 gm/250 ml)	1 bag
Lidocaine	200 mgs
Naloxone	2 mgs
Nitroglycerin spray	1
Sodium bicarbonate	50 mls
Vasopressin	40 units

MINIMUM INVENTORY INTRAVENOUS FLUIDS	QUANTITY
1000 ml normal saline	2
250 or 500 ml normal saline	2

MINIMUM INVENTORY SUPPLIES*	QUANTITY
Back-up power source/adjunct power source (inverter, batters, etc.). Second source required if transporting IABP patients.	1
Cardiac monitor/defibrillator oscilloscope including end tidal CO ₂ detector, external pacemaker, pulse oximeter and optional 12 lead EKG capabilities	1
Cellular phone	1
Infusion pump with 3 chamber drip capability	1

*A CCT Unit must maintain the supplies listed for a BLS unit, an ALS unit **AND** the additional supplies listed here.

SUBJECT: **ALS UNIT INVENTORY**

(PARAMEDIC/MICN)
 REFERENCE NO. 703

PURPOSE: To provide a standardized minimum inventory on all Advanced Life Support (ALS) Units.

PRINCIPLE: Any equipment or supplies carried for use in providing emergency medical care must be maintained in good working order.
 Providers may only carry one narcotic analgesic on the ALS units. Provider Agency Medical Directors may request approval from the EMS Agency's Medical Director to carry Fentanyl.

POLICY: ALS vehicles shall carry the following equipment. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency. Transport vehicles shall also be equipped and supplied according to the Department of the California Highway Patrol, California Administrative Code, Title 13.

MEDICATIONS* (minimum required amounts)			
Albuterol (pre-mixed with NS)	20 mgs	Fentanyl ²	500 mcgs
Adenosine	24 mgs	Glucagon	1 mg
Amiodarone	900 mgs	Midazolam ³	20 mgs
Aspirin (chewable 81 mg)	648 mgs	Morphine sulfate ⁴	32 mgs
Atropine sulfate (1 mg/10 ml)	4 mgs	Naloxone	4 mgs
Calcium chloride	1 gm	Normal saline (for injection)	2 vials
Dextrose 50%	150 mls	Nitroglycerin spray or tablets	1
Dextrose solution 100 gm (glucose paste may be substituted)	1	Ondansetron 4mg ODT	16 mgs
Diphenhydramine	100 mgs	Ondansetron 4mg IV	16 mgs
Disaster Cache (mandatory for 9-1-1 responders) ⁵		Sodium bicarbonate	50 mls
Epinephrine (1:1,000)	7 mgs		
Epinephrine (1:10,000)	10 mgs		

*All sharps must comply with CCR, Title 8, Section 5193, Bloodborne Pathogens

²Fentanyl carried on ALS Unit is not to exceed 1500 mcgs.

³Midazolam carried on ALS Unit is not to exceed 40 mgs.

⁴Morphine sulfate carried on ALS Unit is not to exceed 60 mgs.

⁵Disaster Cache minimum contents include:

(30) DuoDote kits or equivalent

(12) Atropen 1.0 mg

(12) Pediatric Atropen 0.5 mg

EFFECTIVE: 1-1-78
 REVISED: 12-01-14
 SUPERSEDES: 09-01-14

APPROVED: _____
 Director, EMS Agency

 Medical Director, EMS Agency

INTRAVENOUS FLUIDS
(minimum required amounts)

1000 ml normal saline	8 bags	250 or 500 ml normal saline	2 bags
-----------------------	---------------	-----------------------------	---------------

SUPPLIES*
(minimum required amounts)

Adhesive dressing (bandaids)	1 box	End Tidal CO ₂ Detector and Aspirator Adult	1
Airways – Nasopharyngeal Large, medium, small (34-36, 26-28, 20-22)	1 each	Extrication device or short board	1
Airways – Oropharyngeal Large	1	Flashlight	1
Medium	1	Gauze sponges (sterile)	12
Small Adult/Child	1	Gauze bandages	5
Infant	1	Gloves Sterile	2 Pairs
Neonate	1	Gloves Unsterile	1 Box
Alcohol swabs	1 box	Glucometer with strips	1
Backboards	2	Hand-held nebulizer pack	2
Bag-valve device with O ₂ inlet and reservoir Adult and Pediatric	1 each	Hemostats, padded	1
Bag-valve mask Large	1	Intravenous catheters (14G-22G)	5 each
Medium	1	Intravenous Tubing Microdrip	6
Small Adult/Child	1	Macrodrip	6
Toddler	1	Intraosseous Device ^{7,8} Adult	1
Infant	1	Pediatric	1
Neonate	1	9-1-1 paramedic provider agencies only	
Burn pack or burn sheets	1	King LTS-D (Disposable Supraglottic Airway device) Small Adult (Size 3)	1
Cervical collars (rigid) Adult (various sizes)	4	Adult (Size 4)	1
Pediatric	2	Large Adult (Size 5)	1
Color Code Drug Doses LA County Kids	1	Lancets, automatic retractable	5
Contaminated needle container	1	Laryngoscope Handle Adult	1
Continuous Positive Airway Pressure (CPAP) Device ^{6,7}	1	Laryngoscope Blades Adult, curved and straight	1 each
9-1-1 paramedic provider agencies only		Pediatric, Miller #1 & #2	1 each
Defibrillator with oscilloscope	1	Magill Forceps Adult and Pediatric	1 each
Defibrillator electrodes (including pediatric) or paste	2	Mucosal Atomization Device (MAD)	2
ECG Electrodes Adult and Pediatric	6 each	Normal saline for irrigation	1 bottle
ECG, 12-lead capable	1	Needle, filtered-5micron	2
9-1-1 paramedic provider agencies only		Needle thoracostomy kit or 14 G 3.0-3.5" angiocath	2
		OB pack and bulb syringe	1

Endotracheal tubes with stylets Sizes 6.0-8.0	2 each	Oxygen cannulas	3
Oxygen Masks Adult and Pediatric	3 each	Tonsillar tip	1
Pediatric Resuscitation Tape	1	Suction Unit (portable)	1
Personal Protective Equipment/ Body Substance Isolation Equipment mask, gown, eye protection	2 each	Syringes 1ml – 60 ml	assorted
Procedures Prior to Base Contact Field Reference No. 806.1	1	Tape (various types, must include cloth)	1
Pulse Oximeter	1	Tourniquets	2
Radio transmitter receiver ⁶	1	Tourniquets (commercial, for control of bleeding)	2
Saline locks	4	Transcutaneous Pacing ^{7,8}	1
Scissors	1	Tube Introducer	2
Sphygmomanometer Adult/pediatric/thigh cuff	1 each	Vaseline gauze	2
Splints – (long and short)	2 each	Waveform Capnography	
Splints – traction (adult and pediatric)	1 each		
Stethoscope	1		
Suction Instruments (8Fr.-12Fr. Catheters)	1 each		

SUPPLIES* (approved optional equipment)	
Dextrose 25%	Pediatric Laryngoscope Handle FDA-Approved
Dopamine	Resuscitator with positive pressure demand valve (flow rate not to exceed 40L/min)
Hemostatic Dressings ⁸	Vacutainer Tubes
Intravenous Tubing Blood/Shock	

* All sharps must comply with CCR, Title 8, Section 5193, Bloodborne Pathogens.

⁶ Los Angeles County Department of Communications, Spec. No. 2029/2031/2033

⁷ Only for providers that respond to medical emergencies via the 9-1-1 system

⁸ Requires EMS Agency approval, which includes an approved training program and QI method prior to implementation

This policy is intended as an ALS Unit inventory only. Supply and resupply shall be in accordance with Reference No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles.

CROSS REFERENCES:

Prehospital Care Policy Manual:

Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**

Ref. No. 702, **Controlled Drugs Carried on ALS Units**

Ref. No. 710, **Basic Life Support Ambulance Equipment**

Ref. No. 712, **Nurse Staffed Critical Care Inventory**

Ref. No. 1104, **Disaster Pharmaceutical Caches Carried by First Responders**

PURPOSE: To provide a standardized minimum inventory on all Advanced Life Support (ALS) EMS aircraft.

POLICY: Each EMS aircraft shall have on board equipment and supplies commensurate with the scope of practice of the medical flight crew. This requirement may be fulfilled through the utilization of appropriate kits (cases/packs) which can be carried aboard a given flight. ALS EMS aircraft shall have sufficient space to carry the following minimum medical equipment and supplies. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency. Controlled drugs shall be secured on the EMS aircraft in accordance with Reference No. 702, Controlled Drugs Carried on ALS Units.

MEDICATIONS (minimum required amounts)			
Albuterol (pre-mixed with NS)	20 mgs	Fentanyl	500 mcgs*
Adenosine	18 mgs	Glucagon	1 mg
Amiodarone	600 mgs	Midazolam	15 mgs**
Aspirin (Chewable 80 mg)	640 mgs	Morphine sulfate	20 mgs***
Atropine sulfate (1 mg/10 ml)	3 mgs	Naloxone	2 mgs
Calcium chloride	2 gms	Normal saline (for injection)	3 vials
Dextrose 50%	100 mls	Nitroglycerin spray or tablets	1
Dextrose solution 100 gm Glucose paste may be substituted)	1	Ondansetron 4mg ODT	16mgs
Diphenhydramine	100 mgs	Ondansetron 4mg IV	16mgs
Epinephrine (1:1,000)	7 mgs	Sodium bicarbonate	100 mls
Epinephrine (1:10,000)	6 mgs		

* Fentanyl carried on ALS EMS aircraft is not to exceed 1500 mcgs.

** Midazolam carried on ALS EMS aircraft is not to exceed 40 mgs.

***Morphine sulfate carried on ALS EMS aircraft is not to exceed 60 mgs.

INTRAVENOUS FLUIDS (minimum required amounts)			
1000 ml normal saline	4	250 or 500 ml normal saline	1

EFFECTIVE: 9-1-99
REVISED: 12-01-14
SUPERSEDES 07-01-14
APPROVED: _____

Director, EMS Agency

Medical Director, EMS Agency

SUPPLIES (minimum required amounts)			
Adhesive dressing (bandaids)	10	End Tidal CO ₂ Detector/Aspirator (adult)	1
Airways - Nasopharyngeal		End Tidal CO ₂ Monitor (adult)	1
4.5 mm - 9.0 mm	1 each	Extrication device or short board	1
Airways - Oropharyngeal		Flashlight	1
Large	1	Gauze sponges (sterile)	12
Medium	1	Gauze bandages	5
Small	1	Gloves Sterile	2 pairs
Child	1	Gloves Unsterile	1 box
Infant	1	Glucometer with strips	1
Neonate	1	Hand-held nebulizer pack	2
Alcohol swabs	20	Intravenous catheters	
Backboard	1	16g-22G	4 each
Bag-valve device with O ₂ inlet and reservoir		14G (3 inches long)	2
Adult and Pediatric	1 each	Intravenous Tubing	
Bag-valve mask		Microdrip	1
Large	1	Macro drip	4
Medium	1	FDA-Approved Intraosseous device****	
		Adult	1 each
		Pediatric	1 each
Small adult/child	1	King LTS-D (Disposable Supraglottic Airway device) ¹	
		Small Adult (Size 3)	1
Toddler		Adult (Size 4)	1
Infant	1	Large Adult (Size 5)	1
Neonate	1	Lancets (automatic retractable)	5
Burn pack or burn sheets	1	Laryngoscope Handle Adult and Pediatric	1 each
Cervical collars (rigid)	1	Laryngoscope Blades	
Adult (various sizes)	2	Adult, curved and straight	1 each
Pediatric	2	Pediatric, Miller #1 and #2	1 each
Contaminated needle container	1	Mucosal Atomization Device (MAD)	2
Defibrillator with oscilloscope	1	Magill Forceps Adult and Pediatric	1 each
Continuous Positive Airway Pressure (CPAP) Device	1	Needle, filtered-5micron	2
Defibrillator pads or paste	2	Needle thoracostomy kit or 14 G 3"-3.5" angiocath	2 each
ECG, 12-lead capable	1	Noninvasive blood pressure monitor	1
ECG Electrodes Adult and Pediatric	8-10 multi use	Normal saline for irrigation (may stock the smaller 100ml bottle)	1 bottle
Endotracheal tubes with stylets		Oxygen cannulas	2

Sizes 6.0-8.0	2 each	Needle, filtered-5micron	2
Oxygen Masks Adult and Pediatric	2 each	Suction instruments	
Pediatric Resuscitation Tape	1	8 Fr.-16 Fr. Catheters	1 each
Personal Protective Equipment/ Body Substance Isolation Equipment		Tonsilar tip	2
mask, gown, eye protection	2 each	Suction unit (portable)	1
Procedures Prior to Base Contact Field Reference No. 806.1	1	Syringes 1ml - 60 ml	assorted
Pulse oximeter	1	Sphygmomanometer	
Radio transmitter receiver***	1	Adult/pediatric/thigh cuff	1 each
Saline locks	4	Stethoscope	1
Scissors	1	Tape (various types, must include cloth)	assorted
Splints - cardboard (long and short) (or air splints for 4 extremities)	2 each	Tourniquets	2
Splints - traction (adult and pediatric)****	1 each	Tourniquets (commercial, for bleeding control)	2
Suction unit (portable)	1	Transcutaneous Pacing ^{2/3}	1
OB pack and bulb syringe	1	Tube Introducer	2
		Waveform Capnography	

SUPPLIES (approved optional equipment)	
Dextrose 25%	Resuscitator, with positive pressure demand valve (flow rate not to exceed 40L/min)
Dopamine	Transcutaneous Pacing*****
Hemostatic Dressings*****	Vacutainer tubes
Intravenous Tubing/Blood/Shock	

*** Los Angeles County Department of Communications; Spec. No. 2029/2031/2033.

**** One Sager splint may be used for both adult and pediatric

***** Requires EMS Agency approval, which includes an approved training program and QI method prior to implementation

¹ Providers are to have one type of airway adjunct only.

² Only for providers that respond to medical emergencies via the 9-1-1 system

³ Requires EMS agency approval, which includes an approved training program and QI method prior to implementation

This policy is intended as an ALS EMS aircraft inventory only; supply and resupply shall be in accordance with Reference No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles.

CROSS REFERENCES:

Prehospital Care Manual

Reference No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**

Reference No. 702, **Controlled Drugs Carried on ALS Units**

Reference No. 710, **Basic Life Support Ambulance Equipment**

Title 22, Chapter 8, Prehospital EMS Aircraft Regulations

Los Angeles County, Code of Ordinances, Title 7, Business Licenses, Division 2, Chapter 7.16, Ambulances

TREATMENT PROTOCOL: SYMPTOMATIC BRADYCARDIA (ADULT)

1. Basic airway
2. Pulse oximetry
3. Oxygen prn
4. Cardiac monitor: document rhythm and attach ECG strip if dysrhythmia identified
Bradycardia in acute MI may reflect a protective cardiac mechanism
Perform a 12-lead ECG
5. Venous access
6. Supine position prn
7. Advanced airway prn
8. Continuous monitoring en route, assess for signs of poor perfusion
9. Poor perfusion (If the child is off the Broselow™ and adult size, move to the Adult protocol and Adult dosing)

POLICIES 4.14 (Info only)

Atropine

0.5mg IV push

10. If hyperkalemia suspected, **Albuterol** 5mg via continuous mask nebulization two times. ①
11. If no improvement:

Transcutaneous pacing (TCP) if available

Immediate TCP for patients with heart rate equal to or less than 40bpm and SBP equal to or less than 80mmHg in 2nd degree (Type II) heart block or 3rd degree heart block

Do not delay TCP for venous access

Recommended setting initial rate at 70bpm/0mA, slowly increase mA's until capture is achieved

12. ESTABLISH BASE CONTACT (ALL)

13. If hyperkalemia suspected, **Calcium Chloride** 1gram slow IV push over 60 seconds
May repeat one time. ① ②

14. Consider fluid challenge

Normal Saline

10ml/kg IV at 250ml increments

Use caution with rales

15. If TCP is not available consider:

Dopamine (Adult Administration Only) ⑤

400mg/500ml NS IVPB

Start at 30mcgts/min titrate to SBP 90-100mmHg and signs of adequate perfusion or to a maximum of 120mcgts/min

16. If TCP is utilized in the awake patient, consider sedation or analgesia

Midazolam ④

1-2mg slow IV push titrate for sedation

2.5mg IM or IN if unable to obtain venous access

May repeat every 5min, maximum total adult dose 10mg all routes

Morphine ③ ④

2-12mg slow IV push for analgesia

Maximum total adult dose 20mg

17. If patient continues to have symptomatic bradycardia or TCP is not available:

Atropine ④

0.5mg IV push

May repeat every 3-5min, maximum total adult dose 3mg

SPECIAL CONSIDERATIONS

- ① Patients at risk for hyperkalemia are those with renal failure, missed dialysis or patients taking potassium sparing diuretics. EKG signs of hyperkalemia include peaked T-waves, wide QRS, bradycardia, long PR interval, and absent p-waves.
 - ② In consultation with the base hospital, consider sodium bicarbonate 50mEq slow IVP for suspected hyperkalemia.
 - ③ Ondansetron may be administered prior to morphine administration reduce potential for nausea/vomiting.
 - ④ If the child is off the Broselow™ and adult size, move to the Adult protocol and Adult dosing.
 - ⑤ If available.
-

TREATMENT PROTOCOL: DECOMPRESSION EMERGENCY

1. Basic airway
2. Spinal immobilization prn
3. Oxygen via non-rebreather mask at 15L/min or greater/pulse oximetry
DO NOT use oxygen powered breathing devices (i.e., CPAP) on these patients
4. Advanced airway prn
5. Cardiac monitor: document rhythm and attach ECG strip if dysrhythmia identified
6. Venous access prn
7. If hypotensive,
Normal Saline fluid challenge
10ml/kg IV with reassessment at 250ml increments
8. **ESTABLISH BASE CONTACT**
9. If hypotension unresponsive to fluid challenge:
Dopamine ①
400mg/500ml NS IVPB
Start at 30mcgts/min titrate to SBP 90-100mmHg and signs of adequate perfusion or to a maximum of 120mcgts/min
10. If active seizure (may include tonic and/or clonic activity or focal seizure with altered level of consciousness):
Midazolam
2-5mg slow IV push, titrate to control seizure activity
5mg IN or IM if unable to obtain venous access
May repeat one time in 5min, maximum total adult dose 10mg all routes
11. Consider hypothermia
12. Base hospital shall contact the Medical Alert Center for on-call physician and patient destination

POLICIES 4.15 (Info only)

SPECIAL CONSIDERATIONS

- ① If available.
-

TREATMENT PROTOCOL: ALLERGIC REACTION / ANAPHYLAXIS

POLICIES 4.16 (Info only)

1. Simple hives do not require field treatment
2. Basic airway
3. Pulse oximetry
4. Oxygen prn
5. Cardiac monitor: document rhythm and attach ECG strip if dysrhythmia identified
6. Advanced airway prn
7. Venous access prn

ADEQUATE PERFUSION	POOR PERFUSION
<p>8. Epinephrine ①② 0.3mg (1:1,000) IM  Pediatrics: See Color Code Drug Doses/L.A. LA County Kids ③ 0.01mg/kg (1:1,000) IM, maximum single dose 0.3mg for patient weight 30kg or greater</p> <p>9. If wheezing: Albuterol 5mg via-hand-held nebulizer  Pediatrics: See Color Code Drug Doses/L.A. LA County Kids ③</p> <p>10. ESTABLISH BASE CONTACT (ALL)</p> <p>11. If symptoms persist: Epinephrine 0.3mg (1:1,000) IM May repeat every 20min two times for a total of 3 doses  Pediatrics: See Color Code Drug Doses/L.A. LA County Kids ③ Albuterol 5mg vial hand-held nebulizer May repeat prn  Pediatrics: See Color Code Drug Doses/L.A. LA County Kids ③ Diphenhydramine 50mg slow IV push If unable to obtain venous access, 50mg deep IM May repeat in 15min one time, total maximum dose 100mg  Pediatrics: See Color Code Drug Doses/L.A. LA County Kids ③</p> <p>12. Reassess for potential deterioration</p>	<p>8. Epinephrine ①② 0.1mg (1:10,000) slow IV push If unable to obtain venous access, 0.5mg (1:1,000) IM  Pediatrics: See Color Code Drug Doses/L.A. LA County Kids ③ 0.01mg/kg (1:1,000) IM, maximum single dose 0.3mg for patient weight 30kg or greater</p> <p>9. If hypotensive, Normal Saline fluid challenge Adult: 10ml/kg IV at 250ml increments Use caution if rales present Pediatric: 20ml/kg</p> <p>10. ESTABLISH BASE CONTACT (ALL)</p> <p>11. If symptoms persist: Epinephrine 0.1mg (1:10,000) slow IV push May repeat every 3min If unable to obtain venous access, 0.3mg (1:1,000) IM May repeat every 20min two times  Pediatrics: See Color Code Drug Doses/L.A. LA County Kids ③</p> <p>12. If fluid challenge unsuccessful: Dopamine (Adult Administration Only) ④ 400mg/500ml NS IVPB Start at 30mcgts/min titrate to SBP 90-100mmHg and signs of adequate perfusion or to a maximum of 120mcgts/min</p> <p>13. If wheezing: Albuterol 5mg vial hand-held nebulizer May repeat prn  Pediatrics: See Color Code Drug Doses/L.A. LA County Kids ③</p>

SPECIAL CONSIDERATIONS

- ① Monitor vital signs frequently after administration
- ② Epinephrine is the drug of choice for allergic reactions with any respiratory or perfusion component
- ③ If the child is off the Broselow™ and adult size, move to the Adult protocol and Adult dosing.
- ④ If available.

TREATMENT PROTOCOL: CHEST PAIN *

1. Basic airway
2. Pulse oximetry
3. Oxygen prn
4. Cardiac monitor: document rhythm; attach ECG strip if dysrhythmia identified and refer to appropriate treatment protocol
5. Venous access, prn for non-cardiac origin
6. For non-cardiac chest pain or pediatric, use steps 1-4 only ④
7. Perform a 12-lead ECG if suspected cardiac origin ⑤
8. Do not delay necessary medical treatment in order to obtain an ECG on an unstable patient.

POLICIES 4.17 (Info only)

ADEQUATE PERFUSION	POOR PERFUSION
<p>9. Nitroglycerin 0.4mg SL May repeat in 3-5min two times Hold if SBP less than 100mmHg or patient has taken sexually enhancing medication within 48hrs May administer prior to venous access If hypotension develops, place patient supine and prepare to assist ventilations</p> <p>10. Aspirin ① 162-325mg chewable tablets PO, if alert Administer regardless of whether patient is on anticoagulants or has taken aspirin prior to EMS arrival</p> <p>11. CONTINUE SFTP or BASE CONTACT</p> <p>12. If chest pain unrelieved by 3 doses of nitroglycerin: Fentanyl ②③⑥ 50-100mcg slow IV/IO Titrate to pain relief May repeat every 5min Maximum adult dose 200mcg Morphine ②③⑥ 2-12mg slow IV push Titrate to pain relief May repeat every 5min Maximum adult dose 20mg</p>	<p>9. Aspirin ① 162-325mg chewable tablets PO, if alert Administer regardless of whether patient is on anticoagulants or has taken aspirin prior to EMS arrival</p> <p>10. ESTABLISH BASE CONTACT (ALL)</p> <p>11. Consider: Normal Saline fluid challenge 10ml/kg IV at 250ml increments Use caution if rales present</p> <p>12. Dopamine (Adult Administration Only) ⑦ 400mg/500ml NS IVPB Start at 30mcgts/min titrate to SBP 90-100mmHg and signs of adequate perfusion or to a maximum of 120mcgts/min</p> <p>13. Carefully consider: Fentanyl ②③⑥ 50-100mcg slow IV/IO Titrate to pain relief May repeat every 5min Maximum adult dose 200mcg Morphine ②③⑥ 2-12mg slow IV push Titrate to pain relief May repeat every 5min Maximum adult dose 20mg</p>

SPECIAL CONSIDERATIONS

- ① Contraindications: active gastrointestinal bleeding or ulcer disease, hypersensitivity or allergy
- ② Use with caution: in elderly, if SBP less than 100mmHg, sudden onset acute headache, suspected drug/alcohol intoxication, suspected active labor, nausea/vomiting, respiratory failure or worsening respiratory status
- ③ Absolute contraindications: Altered LOC, respiratory rate less than 12breaths/min, hypersensitivity or allergy
- ④ Establish base hospital contact for medication orders if patient with chest pain is 30yrs of age or younger.

- ⑤ If 12-lead ECG indicates ***Acute MI*** (STEMI) or the manufacturer's equivalent of STEMI, do not delay transport. Continue treatment enroute to the STEMI Receiving Center. Base contact is required for notification and destination and may be performed after the transfer of patient care if the receiving SRC is not the base hospital
- ⑥ Ondansetron 4mg IV, IM or ODT may be administered prior to fentanyl or morphine administration to reduce potential for nausea/vomiting.
- ⑦ If available.

TREATMENT PROTOCOL: NON-TRAUMATIC HYPOTENSION

POLICIES 4.18 (Info only)

1. Basic airway
2. Pulse oximetry
3. Oxygen prn
4. Advanced airway prn
5. Cardiac monitor: document rhythm and attach ECG strip if dysrhythmia identified
6. Venous access

CLEAR BREATH SOUNDS	RALES
7. Normal Saline fluid challenge 10ml/kg IV at 250ml increments	7. ESTABLISH BASE CONTACT (ALL)
8. ESTABLISH BASE CONTACT (ALL)	8. If bleeding not suspected: Dopamine (Adult Administration Only) ❶ 400mg/500ml NS IVPB Start at 30mcgts/min titrate to SBP 90-100mmHg and signs of adequate perfusion or to a maximum of 120mcgts/min
9. If bleeding not suspected: Dopamine (Adult Administration Only) ❶ 400mg/500ml NS IVPB Start at 30mcgts/min titrate to SBP 90-100mmHg and signs of adequate perfusion or to a maximum of 120mcgts/min	

SPECIAL CONSIDERATIONS

This treatment protocol includes, but is not limited to, treatment of:

- Cardiogenic shock without dysrhythmia
- Ectopic pregnancy
- Sepsis
- GI bleed
- 2nd or 3rd trimester hemorrhage
- Ruptured aorta

If 2nd or 3rd trimester hemorrhage, left lateral position to decrease pressure on the vena cava, enhance maternal flow and increase perfusion.

❶ If available.

TREATMENT PROTOCOL: RESPIRATORY DISTRESS *

1. Basic airway
2. Pulse oximetry
3. Oxygen prn
4. Venous access prn
5. Cardiac monitor: document rhythm and attach ECG strip if dysrhythmia identified
6. Advanced airway prn
7. Consider CPAP for patients greater than 14 years of age with moderate-to-severe respiratory distress and SBP equal to or greater than 90mmHg ① ②
8. If absent or diminished breath sounds due to severe bronchospasm, refer to Wheezing column
9. If suspected allergic reaction/anaphylaxis, treat by Ref. No. 1242, Allergic Reaction/ Anaphylaxis

POLICIES 4.19 (Info only)

STRIDOR	WHEEZING	BASILAR RALES CARDIAC ETIOLOGY	POOR PERFUSION
<p>10. CONTINUE SFTP or BASE CONTACT</p> <p>11. If severe respiratory distress and croup suspected: Epinephrine (1:1,000) via hand held-nebulizer (HHN)  Pediatric: See Color Code Drug Doses/ L.A. County Kids ④ Less than 1yr of age: 2.5mg diluted with 5ml normal saline via hand-held nebulizer one time. Hold for heart rate greater than 200bpm 1yr of age or older⑤: 5mg diluted with 5ml normal saline via hand-held nebulizer one time Hold for heart rate greater than 200bpm</p>	<p>10. Albuterol 5mg via hand-held nebulizer, may repeat one time  Pediatric: See Color Code Drug Doses/ L.A. County Kids ④ Less than 1yr of age: 2.5mg 1yr of age or older: 5mg Wheezing may be an initial sign of pulmonary edema; therefore, reassess breath sounds frequently</p> <p>11. CONTINUE SFTP or BASE CONTACT</p> <p>12. If deteriorating respiratory status: Epinephrine 0.3mg (1:1,000) IM  Pediatrics: See Color Code Drug Doses/L.A. County Kids ④ 0.01mg/kg (1:1,000) IM, maximum single dose 0.3mg for patient weight 30kg or greater</p>	<p>10. Nitroglycerin SL 0.4mg for SBP equal to or greater than 100mmHg 0.8mg for SBP equal to or greater than 150mmHg 1.2mg for SBP greater than 200 May repeat in 3-5min two times, administer subsequent doses based on SBP listed above Hold if SBP less than 100mmHg or patient has taken sexually enhancing drugs within 48hrs May administer prior to venous access If hypotension develops, place patient supine and prepare to assist ventilations</p> <p>11. If wheezing: Albuterol 5mg via hand-held nebulizer, may repeat one</p>	<p>10. ESTABLISH BASE CONTACT (ALL)</p> <p>11. Consider: Normal Saline fluid challenge 10ml/kg IV at 250ml increments</p> <p>12. Dopamine (Adult Administration Only) ⑤ 400mg/500ml NS IVPB Start at 30mcgts/min titrate to SBP 90-100mmHg and signs of adequate perfusion or to a maximum of 120mcgts/min</p> <p>13. Consultation with base physician strongly recommended</p>

TREATMENT PROTOCOL: RESPIRATORY DISTRESS *

	<p>Monitor vital signs frequently after administration</p> <p>Due to cardiovascular effects, caution in patient older than 40yrs of age or pregnant</p>	<p>time</p> <p>Reassess breath sounds frequently</p> <p>May be given simultaneously with nitroglycerin based on clinical assessment of the individual</p> <p>12. CONTINUE SFTP or BASE CONTACT</p>	
--	---	---	--

SPECIAL CONSIDERATIONS

- ① Acute respiratory distress, consider:
 - Foreign body obstruction
 - Epiglottitis/croup
 - Spontaneous pneumothorax
 - Inhalation injury
 - Pulmonary embolism
- ② CPAP may be initiated for moderate-to-severe respiratory distress at any time during treatment unless contraindicated
 - Providers utilizing CPAP should follow departmental and manufacturer's recommendations
 - Monitor vital signs frequently; be prepared to assist ventilations if the patient worsens on CPAP or is unable to tolerate therapy
- ③ If the HHN bowl maximum volume is 6ml, the 5mg dose for 1yr and older can be divided in ½ and two treatments administered.
- ④ If the child is off the Broselow™ and adult size, move to the Adult protocol and Adult dosing.
- ⑤ If available

MEDICAL CONTROL GUIDELINE: INTRAOSSEOUS ACCESS

PRINCIPLES:

POLICIES 4.20 (Info only)

1. Intraosseous (IO) access is indicated for adult and pediatric patients in cardiopulmonary arrest when intravenous (IV) access is not possible, unlikely to be successful, or cannot be achieved quickly.
2. IO access is approved under the local optional scope of practice for paramedics who have completed specialized training and are employed by an approved IO provider. All IO training materials and quality improvement review must be approved by the EMS Agency prior to implementation.
3. IO contraindications:
 - a. Inability to identify landmarks
 - b. Lower extremity deformity/fracture
 - c. Failed IO attempt in the same bone
4. Possible IO complications:
 - a. Compartment syndrome
 - b. Growth plate injury
 - c. Skin or bone infection
 - d. Fracture of the involved bone
 - e. Fat embolism
 - f. Local infiltration of fluid

GUIDELINES:

1. IO needle placement is approved for the flat surface of the non-traumatized proximal medial tibia, utilizing the tibial tuberosity as the landmark for proper placement. Preferred IO site is free from signs of skin or bone infection.
2. Explain IO procedure to the family or caregiver if present during the resuscitation.
3. Prior to use, verify patency by attempting to aspirate blood or a small amount of bone marrow, and then slowly flush with normal saline. The IO site can be used if it flushes easily without signs of swelling.
4. If swelling occurs or if IO needle becomes dislodged, stop infusion, remove IO needle, and apply pressure bandage to the IO site.
5. IO placement may be attempted once per tibia.
6. Document the IO needle gauge and site when IO access is attempted and/or achieved.
7. Providers approved to utilize IO for conditions other than cardiopulmonary arrest should utilize lidocaine for patients responsive to pain. Pre-infuse lidocaine 2% (preservative and epinephrine free) at the dosage listed below. Slow infusion is necessary to ensure the lidocaine remains in the medullary space
 - a. Adults: 40mg slow push over 1-2 minutes
 - b. Pediatric: 0.5mg/kg, maximum dose 40mg, slow IO push over 1-2 minutes



EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate and quality
emergency and disaster
medical services.*

August 14, 2014

TO: Participating and New Enrollment Physicians

FROM: Cathy Chidester *CC*
Director

SUBJECT: **PHYSICIAN SERVICES FOR INDIGENTS PROGRAM
ENROLLMENT DEADLINES BY FISCAL YEAR**

This memo is in follow up to the memo dated June 12, 2013, regarding the Physician Services for Indigents Program (PSIP) and the announcement of a three-year enrollment period, which covers the County's Fiscal Years (FYs) from July 1, 2013 through June 30, 2016.

As stated, the enrollment period covers three years. Providers only need to enroll one time and they do not need to enroll in the first year to be eligible for future year participation. However each FY has a deadline for enrollment to be able to submit claims for that FY. Below are the deadlines for enrollment and claim submission for each FY:

Fiscal Year	Service Dates Covered	Enrollment Deadline	Claim Submission Deadline
FY 2013-14	July 1, 2013 – June 30, 2014	October 31, 2014	October 31, 2014
FY 2014-15	July 1, 2014 – June 30, 2015	October 31, 2015	October 31, 2015
FY 2015-16	July 1, 2015 – June 30, 2016	October 31, 2016	October 31, 2016

If you have any questions regarding enrollment, please contact the County's Contract Claims Adjudicator, American Insurance Administrators (AIA), at (800) 303-5242.



Health Services
<http://ems.dhs.lacounty.gov>



EMERGENCY MEDICAL
SERVICES AGENCY

August 14, 2014

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

TO: See Distribution

FROM: Cathy Chidester
Director

SUBJECT: **PHYSICIAN SERVICES FOR INDIGENTS PROGRAM
NOTICE OF PROPOSED REIMBURSEMENT RATE
INCREASE FOR SERVICES PROVIDED IN FISCAL
YEAR 2014-15**

Cathy Chidester
Director

William Koenig, MD
Medical Director

The Department of Health Services is proposing to increase the Physician Services for Indigents Program Emergency Room reimbursement rate to 10.5% of the Official County Fee Schedule, based on the projected revenue available for the program and the projected claims. This rate increase will be effective for claims submitted for Fiscal Year 2014-15 (July 1, 2014 to June 30, 2015 services).

10100 Pioneer Blvd, Suite 230
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

A Public Hearing will be held as part of the Emergency Medical Services Commission meeting at the EMS Agency on:

Date: September 17, 2014
Time: 1:00 p.m.
Location: EMS Agency
10100 Pioneer Boulevard
Santa Fe Springs, CA 90670
Hearing Room – First Floor

*To ensure timely,
compassionate and quality
emergency and disaster
medical services.*

If you have any questions please contact Kay Fruhwirth, Assistant Director at (562) 347-1602.

CC:kf

Distribution:
Board of Supervisor Health Deputies
County Auditor-Controller
Department of Health Services Director
Department of Health Services Deputy Director Strategic Planning
Hospital Association of Southern California
Physician Reimbursement Advisory Committee Members
PSIP Enrolled Physicians



Health Services
<http://ems.dhs.lacounty.gov>



Health Services
LOS ANGELES COUNTY

BUSINESS 5.5

October 6, 2014

**Los Angeles County
Board of Supervisors**

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

TO: Supervisor Don Knabe, Chair
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: REVISED REIMBURSEMENT RATES FOR PHYSICIAN SERVICES FOR INDIGENTS PROGRAM (PSIP)

Mitchell H. Katz, M.D.
Director

Hai F. Yee, Jr., M.D., Ph.D.
Chief Medical Officer

Christina R. Ghaly, M.D.
Deputy Director, Strategic Planning

As approved by your Board on October 25, 2011, the Department of Health Services (DHS) is exercising its delegated authority to increase the Fiscal Year (FY) 2014-15 Physician Services for Indigents Program (PSIP) reimbursement rate from 9% to 10.5% of the Official County Fee Schedule (OCFS). This increase is based on an actual surplus for FY 2012-13 and a projected surplus for FY 13-14.

DHS began the public process necessary to implement the proposed PSIP reimbursement rate increase to participating non-County physicians on August 14, 2014, since continuing the reimbursement at the current 9% of OCFS would result in a projected surplus again for FY 2014-15. As required by the October 25, 2011 Board Motion, DHS notified the Hospital Association of Southern California, all participating providers, the Physician Reimbursement Advisory Committee (PRAC), your Board Health Deputies and the County Auditor Controller of the proposed rate increase by sending out a notice of the proposed rate increase and upcoming Public Hearing. The Emergency Medical Services (EMS) Agency conducted the public hearing on September 17, 2014, as part of the EMS Commission meeting business. Attached are the comments received from the providers and other attendees.

PSIP Background

Developed in 1987 to reimburse private physicians for indigent care, PSIP has historically been funded by a combination of: 1) penalty assessments collected for certain criminal offenses and vehicle violations, known as "EMS/Maddy Funds"; 2) Los Angeles County "Measure B" property assessment funds designated for trauma centers (partial offset); and 3) the EMSA. EMSA funds were originally placed into the State budget in 2002 to offset reductions in Proposition 99 Tobacco Tax funds allocated by the California Healthcare for Indigents Program. These EMSA funds were allocated to counties based on each county's share of the financial burden to provide health care services to those who are unable to pay. Unfortunately, the State's Final FY 2009-10 budget eliminated the line item called EMSA, which resulted in a statewide reduction of \$24.8 million intended to supplement the physician component of each county's

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

www.dhs.lacounty.gov

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

www.dhs.lacounty.gov



EMS/Maddy Fund. This resulted in a loss of \$8.8 million (or 30 percent of the funding) for Los Angeles County's PSIP Emergency Room (ER) and PSIP Trauma Physician programs.

As a result of this loss of State revenue, the Board approved the PSIP reimbursement rate reduction from 27% to 18% for FY 2009-10 on February 16, 2010. Based on previous projections, the rate remained at 18% for FY 2010-11. However, on October 18, 2011, the Board approved a reimbursement rate reduction to 12% for FY 2010-11 outstanding claims and established the rate at 14% for FY 2011-12 claims. Based on the continuous trends of decreasing revenue and increase in ER claim volume, for FY 2012-13 the rate was decreased to 9%.

DHS actual experience for FY 2012-13, based on the 9% reimbursement rate for ER claims resulted in a surplus of \$1,184,233 after all eligible claims were adjudicated. This surplus was subsequently distributed as the law requires remaining funds to be distributed proportionately to all physicians based on claims submitted and paid during that year.

Future of PSIP

With the implementation of the Patient Protection and Affordable Care Act, a significant number of the underinsured or uninsured, low-income residents of Los Angeles County should gradually have health insurance, either through the Medicaid expansion or the State Health Insurance Exchange. This health insurance expansion will have two positive effects on the PSIP program. First, physicians will now be able to bill full Medi-Cal rates for patients for whom they were previously receiving the lower PSIP rate. Second, since a significant portion of the previously under-insured and uninsured will have medical insurance, the number of PSIP claims should drop. Therefore, we anticipate that in subsequent FYs we may be able to further adjust the percentage of the Official County Fee Schedule for reimbursement of PSIP claims. We will monitor the changes in claims and revenues closely and inform your Board if appropriate action is necessary.

If you have any questions, please contact me or Cathy Chidester, EMS Agency Director, at (562) 247-1604.

Attachment

MHK:kf

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

Public Hearing

Physician Services for Indigents Program (PSIP) – Proposed Reimbursement Rate Increase for Services Provided in FY 2014-15

Kay Fruhwirth, EMS Assistant Director, provided a brief history of the PSIP program. Over the past four or five years the funding for indigent patients services has declined. The big decline was in FY 2008-09 when the EMSA Fund was deleted from the Governor's budget so that funding was lost through the State. The program is a combination of funding primarily through the Maddy Fund (SB 612), SB 1773 and some Measure B and Impacted Hospital Program funding. Back in 2012 there was a significant shortfall in funding the PSIP and the reimbursement rate declined to nine-percent of the Official County Fee Schedule (OCFS). At that time the County had to reduce the reimbursement rate to ensure that the available funding would cover the increasing number of physicians enrolled in the program and increasing number of claims being submitted against the decreasing funding. This was done to ensure that adequate funding was available to cover the projected increase in claims. The actual payment of Fiscal Year (FY) 2012-13 claims was not as high as estimated and resulted in a surplus. Based on this experience and the projection that there will be a surplus for FY 2013-14, DHS wanted to reduce the potential of having a surplus for FY 2014-15, and proposed increasing the reimbursement rate for FY 2014-15.

The proposal before you today is to increase the FY 2014-15 reimbursement rate to 10.5% of the OCFS. Johnny Wong from DHS Fiscal Services is attending today's meeting to provide an overview of the PSIP financial performance and the information that went into determining the reimbursement rate increase for FY 2014-15. A summary of the financial performance was distributed.

Johnny Wong, of DHS Fiscal Services, presented the financial overview of PSIP. Current payment of FY 2013-14 PSIP claims are based upon the 9% of the OCFS reimbursement rate. We are using the actual number of claims paid for FY 2012-13 to forecast the payment of claims for FY(s) 2013-14 and 2014-15, and show a small decrease in claims for 2014-15. One of the major factors in causing a decrease in the number of claims is the implementation of the Affordable Care Act (ACA), which took effect on January 1, 2014. Unfortunately, because of claims processing time lags, ranging from four months to seven months from service date, we do not have a clear picture on how the ACA has impacted the number of claims that will be submitted for FY 2014-15. The numbers are only an estimate. We do know that ACA is having some effect on the number of claims paid under PSIP in LA County. To forecast the reimbursement rate for 2014-15, a few months ago, we looked at the national data on the impact of the ACA on uninsured rates and found that uninsured rates declined about 2.5%. We also looked at our uninsured patients, who were currently being billed to the PSIP, to see if we could project what percentage of this population would qualify for Medi-Cal. We found that about 40% of the PSIP patient population did not have a valid social security number and therefore would not qualify for expanded Medi-Cal coverage under ACA.

After the overview of the program and the financial projection, the hearing was opened for public comment and questions.

Commissioner Binch

Q. Who did you coordinate with on your estimation of number of 2014-15 claims?

A. We reviewed and analyzed our in-house claims data provided by AIA (our claims adjudicator), looked at the year-to-date and month-to-month trends, reviewed publications on the impact of the ACA on uninsured rates, and consulted with EMS.

Q. Did you use any independent experts to look at the preliminary numbers?

A. No, other than what was published.

Q. What's the contingency plan if the number of claims is substantially lower than forecasted? Will you be able to reach back and increase or decrease the compensation based on the actual forecast?

A. Each year the funds allocated to the program must be distributed in that year. When there is a surplus at the end of the year, a raise-up is done and the balance is distributed proportionally, as required by law, based on all paid claims processed during that year. DHS is trying to be conservative in its estimate to avoid running out of funds that would warrant any decrease in the reimbursement rate during the year.

General comment made by Commissioner Binch:

I am concerned about the very small amount of the forecast of the proposed rate increase considering we were able to catch up the deficit from previous year and financing this year. With that deficit financed and the Affordable Care Act's impact on the number of claims, I would have hoped to see a higher percentage and if at all possible in any way reconcile that, and compensate all claims based on later revisions.

Commissioner Tillou

Q. When do you anticipate that DHS will start reimbursing at the 2014-15 rate?

A. October 2014, bills will be accepted for the 2014-15 rate.

Q. Do you know what the 2013-14 surplus rate is at this time?

A. No, because we are still paying 2013-14 claims. Currently, we anticipate a \$2 million surplus.

Commissioner Flashman

- Q. Will the pay-out be expedited? A six to seven month payout is not timely.
- A. If we get a clean claim it is paid right away (within 20 working days). If there is a problem with the claim or it is incomplete, it is denied and this process can extend the payment period.
- Q. What is the average amount of time it takes for claims to be paid?
- A. Kay Fruhwirth indicated that she did not have the exact time but will ask AIA to provide the information on claims processing and will provide this back to the EMSC.

Jamie Garcia, Vice President, Hospital Association of Southern California thanked the EMSC for holding a public hearing on PSIP. He remarked that this was a turning point in a positive direction as we are discussing an increase instead of a decrease in physician reimbursement.

There were no other comments from the audience on PSIP.

PHYSICIAN SERVICES FOR INDIGENT PROGRAM CLAIMS PROCESSING TIME LINE

ER CLAIM

- Physician: **90 calendar days** from patient discharge for collection efforts prior to submission of claim
- AIA: **20 working days** from receipt of claim to either approve or deny claim
- Appeal: Physician has **30 days** to re-submit any denied claim with a maximum of two **(2) appeals**. If provider is not satisfied with the decision, claim is reviewed by the Physician Reimbursement Advisory Committee (PRAC) for final resolution, which requires adding an additional **20 working days for each cycle** for AIA to process Appeals (paid/denied).

IMPACTED HOSPITAL PROGRAM (IHP)

Same as ER Claim, however; AIA's **20 working days** process time is counted from the date of IHP patient data match (i.e., patient and service date data are matched between hospital claim and physician claim). Since IHP hospitals is given an extended period (between 90 days to 180 days from patient discharge) to submit the claim, the processing time line for IHP claims can range from 150 to 240 calendar days, not including appeals.

OTHER FACTORS

Many other factors are involved that could extend the time from claim submission to payment, which include whether the provider is already enrolled in PSIP or still needs to enroll, claim submission issues, and what specific program (ER, Trauma or IHP) is being billed.

Physician Services for Indigents Program
Claim Processing





EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate, and quality
emergency and disaster
medical services*

July 3, 2014

Stephen R. Shea, Medical Director
Long Beach Fire Department
3205 Lakewood Boulevard
Long Beach, CA 90808-1733

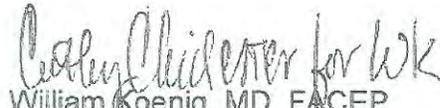
Dear Dr. Shea:

The utilization of Standing Field Treatment Protocols (SFTP) as stated in your letter is appropriate. The initiation of SFTP protocols should be only by two SFTP trained paramedics responding to a 9-1-1 call – whether en route or at scene.

If additional treatments are needed en route or if additional treatment protocols are initiated, then base hospital contact shall be initiated by the single paramedic.

If you have any questions, please call me at (562) 347-1600 or email me at Wknoenig@dhs.lacounty.gov.

Very truly yours,


William Koenig, MD, FACEP
Medical Director

- c: Mike Duree, Fire Chief, Long Beach Fire
- Mike Sarjeant, Deputy Chief, Operations, Long Beach Fire
- Richard Tadeo, Assistant Director, EMS Agency



Health Services
<http://ems.dhs.lacounty.gov>



EMERGENCY MEDICAL
SERVICES AGENCY

BUSINESS 5.6

October 22, 2014

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

To ensure timely,
compassionate, and quality
emergency and disaster
medical services

Michael A. Duree, Fire Chief
City of Long Beach Fire Department
3205 Lakewood Boulevard
Long Beach, CA 90808

Dear Chief Duree:

This letter is to request a written plan for improvement to the Rapid Medic Deployment pilot project. The Emergency Medical Services (EMS) Agency has been monitoring the Rapid Medic Deployment pilot project for compliance with Reference No. 407, Advanced Life Support Unit Alternate Staffing Pilot Program Requirements (attached). Specifically, Reference No. 407, I., K. states:

Provider Agency shall ensure that the EMS incidents responded to by One-Plus-One staffed ALS units arrive at the scene of the incident within 3 minutes of each other 95% of the time. There shall be a mechanism in place to track and report within 24 hours each EMS response and the ALS units that responded to the incident; both individual EMS incidents and in aggregate format.

The EMS Agency analyzed data from both the City of Long Beach Fire Department (LBFD) Computer Aided Dispatch (CAD) system and patient care report forms and found the RMD program to be out of compliance. On September 8, 2014 the EMS Agency staff met with you and your senior management to discuss the two paramedics on scene times and further review your data reports.

Your staff requested additional time to review the CAD data and resubmit a report. On September 9, 2014, it was clear that the second paramedic is not arriving on the scene of the "Charlie" calls within three minutes, 95% of the time (attached). An email was sent to your staff, copied to you, requesting a written plan for improvement as soon as possible and implementation of the plan no later than October 1, 2014.

To date the EMS Agency has not received a plan for improvement and has not been made aware of any changes to the RMD program to ensure timely arrival of two paramedics to the scene of all "Charlie" calls.

Please submit your department's written plan for improvement ensuring delivery to the EMS Agency by November 3, 2014. The plan needs to include an implementation date no later than November 15, 2014.



Health Services
<http://ems.dhs.lacounty.gov>

Michael A. Duree, Fire Chief

October 22, 2014

Page 2

If LBFD is not able to provide the plan and/or demonstrate significant improvement to the two paramedic on scene time, the EMS Agency will consider termination of the pilot project as defined in Reference No. 407.

Thank you for your attention to this matter.

Very truly yours,



Cathy Chidester
Director

Attachment

c: EMS Commission
DSMB
Medical Director, LBFD
Long Beach City Manager
Medical Director, EMS Agency

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **ADVANCED LIFE SUPPORT (ALS) UNIT
ALTERNATE STAFFING PILOT PROGRAM
REQUIREMENTS**

REFERENCE NO. 407

PURPOSE: To define the requirements and roles for public safety agencies to implement a pilot program.

AUTHORITY: Health & Safety Code, Division 2.5, Sections 1797.214, 1798
California Code of Regulations, Title 22, Sections 10062; 100063; 100064;
100139; 100142; 100145; 100169

DEFINITIONS:

Advanced Life Support (ALS) Unit: An emergency medical services (EMS) response unit staffed according to Ref. No. 408, Advanced Life Support (ALS) Unit Staffing, equipped as outlined in Ref. No. 703, ALS Unit Inventory, and approved by the EMS Agency.

ALS First Responder Assessment Unit: A non-transporting emergency response vehicle utilized by an approved paramedic service provider for 9-1-1 responses which is staffed, at minimum, by one paramedic who is licensed by the State of California, accredited by the County of Los Angeles, and equipped as outlined in Ref. No. 704, Assessment Unit Inventory.

ALS Unit Alternate Staffing Program: An EMS ALS response unit that is NOT staffed according to Ref. No. 408, Advance Life Support (ALS) Unit Staffing; but authorized by the EMS Agency to conduct a pilot program:

One-Plus-One Staffing: Two paramedics who together provide patient care at the scene of a 9-1-1 call but do not arrive on the same vehicle.

Emergency Patient Transport Unit: a 9-1-1 response vehicle utilized for patient transport, may be staffed with at least two State certified EMTs [Basic Life Support (BLS) Unit], or two State licensed paramedics [Advanced Life Support (ALS) Unit], or a combination thereof (ALS Unit Alternate Staffing).

PRINCIPLES:

1. An alternate staffing program shall consist of a pilot program endorsed by the EMS Commission and authorized by the EMS Agency for a maximum of two years.
2. Continued utilization of an alternate staffing program beyond the maximum two year pilot program shall be approved or discontinued by the EMS Agency based on outcome data and efficacy of the pilot program.
3. The type of Emergency Patient Transport Unit (BLS, ALS, or ALS Alternate Staffing) shall be determined based on the patient's medical need and shall be

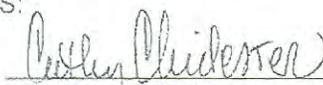
EFFECTIVE: 09-01-13

PAGE 1 OF 5

REVISED:

SUPERSEDES:

APPROVED:


Director, EMS Agency


Medical Director, EMS Agency

SUBJECT: **ADVANCED LIFE SUPPORT (ALS) UNIT
ALTERNATE STAFFING PILOT PROGRAM
REQUIREMENTS**

REFERENCE NO. 407

commensurate with the scope of practice of the transporting EMS personnel. The Emergency Patient Transport Unit personnel shall be responsible for the care and safety of the patient until transfer of care to hospital staff. Team members shall strictly adhere to their respective scope of practice.

4. The EMS Agency may conduct unannounced periodic site visits and direct field observation to evaluate the alternate staffing program.
5. At any point after the pilot begins, the EMS Agency may order the pilot slowed, stopped, modified and/or reversed. If any such action is ordered by the EMS Agency, the Agency shall state cause(s) for the action(s) in writing.

POLICY:

I. Provider Agency Responsibilities

- A. Submit a written request for authorization to implement an alternative staffing pilot program, signed by the Fire Chief and City Manager, signifying the City's acknowledgement and understanding of the pilot program requirements as outlined in this policy.
- B. Quality Improvement
Maintain a comprehensive, approved Quality Improvement program that includes indicators specific to the alternate staffing program.
- C. Data
 1. Implement a data system that adheres to all electronic data submission requirements as prescribed by the EMS Agency.
 2. The data collection system shall include a methodology for obtaining patient outcome data.
- D. Required Medical Oversight
 1. Appoint a medical director who must meet the requirements specified in Ref. No. 411, Provider Agency Medical Director.
 2. Select an EMS educator to be responsible for providing oversight and education related to the alternate staffing program.
- E. Controlled Substances
 1. Have a mechanism to procure, store and distribute controlled drugs through a physician who meets the requirements specified in Ref. No. 411, Provider Agency Medical Director, or Ref. No. 410, Drug Authorizing Physician for Provider Agencies.
 2. Procurement, storage and distribution of controlled drugs shall be consistent with Ref. No. 702, Controlled Drugs Carried on ALS Units.

3. At least one ALS Unit responding on scene shall carry a full complement of controlled drugs as specified in Ref. No. 702.

F. Education and Training

1. Provide an Alternate Staffing Training Program approved by the EMS Agency and maintain training rosters. The training program shall include a provider agency specific orientation process which outlines and documents the team members' competency in their roles and responsibilities.
2. All team members shall attend the training program prior to being assigned to an alternately staffed ALS unit.
3. Conduct initial and annual skills competency evaluation of EMTs assigned to an alternately staffed ALS unit.
4. Ensure that all EMTs participating in the alternate staffing program attend the annual EMS Update training in those areas applicable to the EMT scope of practice. Maintain documentation verifying skills competency and completion of EMS Update training.

G. Use pre-arrival instructions when dispatching alternately staffed ALS units.

H. Utilize mobile, hands-free communication devices to allow the paramedic to establish and maintain base hospital contact during transport while continuing care in the patient compartment of the ambulance.

I. Report violations as outlined in Ref. No. 214, Base Hospital and Provider Agency Reporting Responsibilities.

J. Utilization of Standing Field Treatment Protocols (SFTPs) by Authorized SFTP Providers

1. Public safety agencies authorized to utilize Standing Field Treatment Protocols (SFTPs) and approved to implement the alternate staffing program may use SFTPs as follows:
 - a. Two SFTP-trained paramedics have responded to a 9-1-1 call and together are caring for a patient on scene.
 - b. SFTPs may only be used when two paramedics accompany the patient in the ambulance during transport.
 - c. Treatment is provided in accordance with Reference No. 813, Standing Field Treatment Protocols.
 - d. A single paramedic with an EMT partner must establish base hospital contact and provide a full report when transporting an ALS patient.

- K. Provider Agency shall ensure that EMS incidents responded to by One-Plus-One staffed ALS units arrive at the scene of the incident within 3 minutes of each other 95% of the time. There shall be a mechanism in place to track and report within 24 hours each EMS response and the ALS units that responded to the incident; both individual EMS incidents and in aggregate format.

- L. Provider Agency shall develop and make publicly available for review, a comprehensive action plan and time table to govern implementation of the project on a phased in basis such that no more than five (5) percent of the County's population at a time is affected by conversion from the current two-paramedic ALS Unit staffing requirement (Ref. No. 408) to an Alternate ALS Unit Staffing Program.

- M. Prior to implementation, Provider Agency shall prepare and submit a detailed financial and operational contingency plan which is sufficient to halt and reverse all or any part of the pilot implementation.

- II. EMT Roles and Requirements
 - A. All EMTs participating in the alternate staffing program shall:
 - 1. Be currently certified as an EMT in the State of California
 - 2. Have completed the Los Angeles County Scope of Practice Training Program
 - 3. Have completed the provider agency specific alternate staffing training program
 - 4. Have demonstrated competency in the initial and annual evaluation of the following skills:
 - a. Basic airway management and oral suctioning
 - b. Assist with endotracheal intubation by ventilating the patient or handing equipment to the paramedic
 - c. Assemble IV and blood glucose testing equipment
 - d. Assist with cardiac monitoring, to include obtaining 12-lead ECGs
 - e. Assist with set-up for defibrillation and transcutaneous pacing
 - f. Assist with continuous positive airway pressure therapy
 - g. Have completed the annual EMS Update training in those areas applicable to the EMT Scope of Practice.

SUBJECT: **ADVANCED LIFE SUPPORT (ALS) UNIT
ALTERNATE STAFFING PILOT PROGRAM
REQUIREMENTS**

REFERENCE NO. 407

5. Know how to operate the paramedic communications equipment
 - a. In the event the paramedic cannot establish base hospital contact, the EMT shall notify the receiving hospital of patient arrival.
 - b. The EMT may not accept patient care orders or relay base hospital orders to the paramedic.
6. Ensure that the ambulance is consistently stocked according to the recommended inventory of emergency care equipment and supplies as outlined in Ref. No. 710, Basic Life Support Ambulance Equipment

III. **Paramedic Role and Requirements**

- A. All paramedics participating in the alternate staffing program shall:
 1. Be currently licensed by the State of California and accredited in the County of Los Angeles.
 2. Have completed the provider agency specific alternate staffing training program.
 3. Function as the primary care provider until transfer of patient care.
 4. Ensure that all team members adhere to their respective scope of practice (Ref. No. 802, EMT Scope of Practice and Ref. No. 803, Los Angeles County Paramedic Scope of Practice).
 5. Ensure compliance with Ref. No. 702, Controlled Drugs Carried on ALS Units and Ref. No. 703, ALS Unit Inventory
 6. Ensure the appropriate completion of the EMS Report Form (hard copy and/or electronic format)

CROSS REFERENCES:

Prehospital Care Manual:

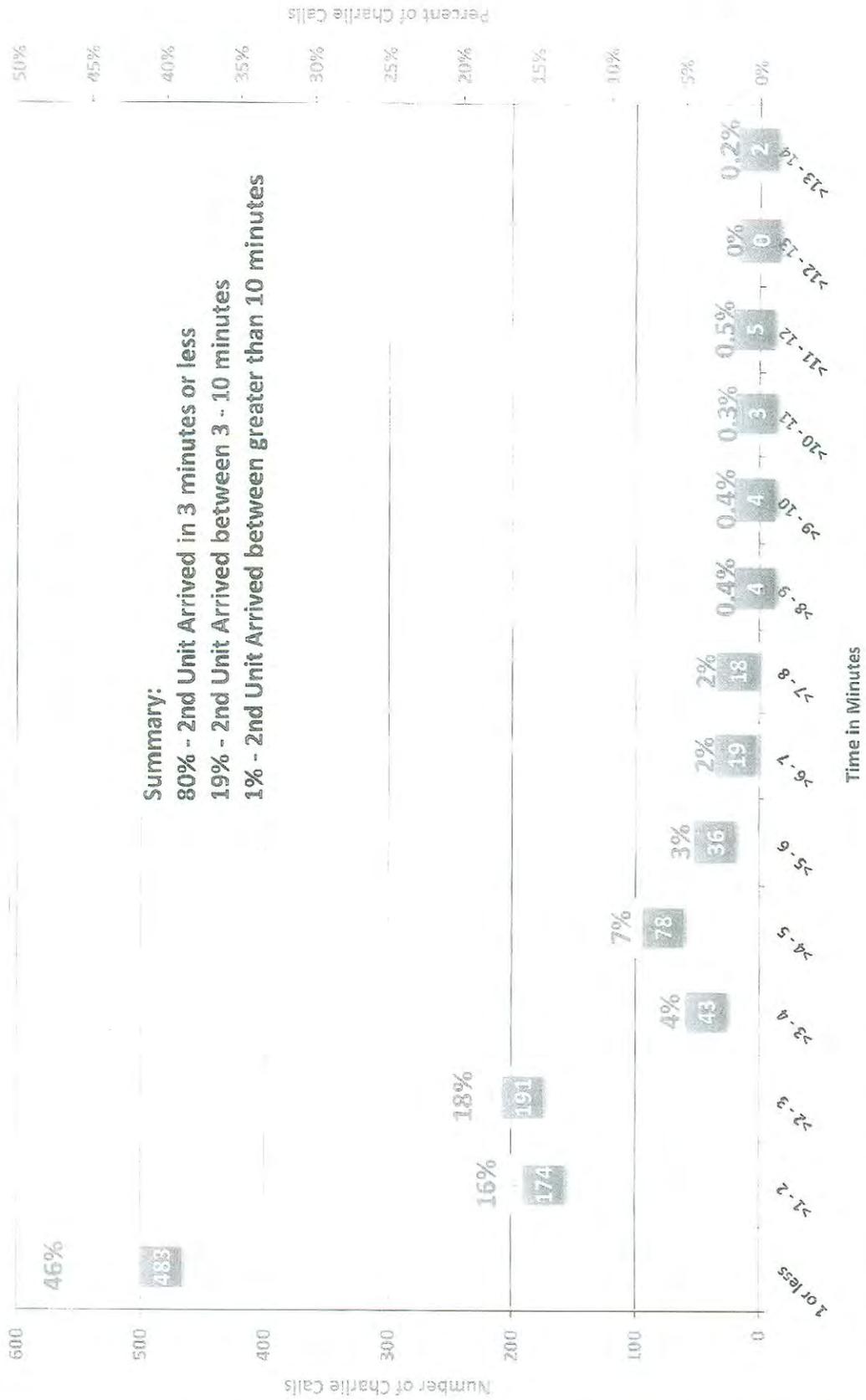
Ref. No. 214,	Base Hospital and Provider Agency Reporting Responsibilities
Ref. No. 227,	Dispatching of Emergency Medical Services
Ref. No. 407.1,	One-and-One ALS Unit Alternate Staffing Report (to be developed)
Ref. No. 408,	Advanced Life Support (ALS) Unit Staffing
Ref. No. 410,	Drug Authorizing Physician for Provider Agencies
Ref. No. 411,	Provider Agency Medical Director
Ref. No. 702,	Controlled Drugs Carried on ALS Units
Ref. No. 703,	ALS Unit Inventory
Ref. No. 710,	Basic Life Support Ambulance Equipment
Ref. No. 802,	EMT Scope of Practice
Ref. No. 803,	Los Angeles County Paramedic Scope of Practice

LBFD: Time First Unit Arrived On-Scene to Time Second Unit Arrived On-Scene

CHARLIE DISPATCH ONLY (n=1,060)

July 10 - July 31, 2014

Data submitted by LBFD from CAD System



Summary:

- 80% - 2nd Unit Arrived in 3 minutes or less
- 19% - 2nd Unit Arrived between 3 - 10 minutes
- 1% - 2nd Unit Arrived between greater than 10 minutes

Lbfd: Time First Unit Arrived On-Scene to Time Second Unit Arrived On-Scene

CHARLIE DISPATCH ONLY (n=1,522)

August 1 - August 31, 2014

Data submitted by Lbfd from CAD System





CITY OF LONG BEACH

FIRE DEPARTMENT

Business 5.6

3205 Lakewood Boulevard • Long Beach, CA 90808-1733 • Telephone (562) 570-2500 • FAX (562) 570-2506

MICHAEL A. DuREE
FIRE CHIEF

October 28, 2014

Cathy Chidester
Director of EMS
Los Angeles County EMS Agency
10100 Pioneer Blvd., Suite 200
Santa Fe Springs, CA 90670

Ms. Chidester,

The Long Beach Fire Department prides itself in achieving excellence in protecting the public we serve. We have always strived for new ways to improve our service to the community. The Rapid Medic Deployment (RMD) model is one of many ways we have raised the bar in providing excellent care to the citizens and visitors to Long Beach.

The RMD plan has been in operation since July 10, 2014 and we have already seen improvements in many areas of service delivery. When we compare post RMD data to the previous year, we have been able to deliver the first ALS capable resource on scene 50 seconds faster since the inception of the program. We have done this by increasing our number of Paramedic Assessment Units (PAUs) from 9 to 17. This has allowed us to dispatch a paramedic to almost every medical emergency in the city. Prior to RMD with only 9 PAU's, 66.5% of our responses didn't receive ALS level care until the Paramedic Unit arrived. The original engine company could start assessing at a BLS level, but no ALS level care could be provided until the paramedics arrived.

Within reference 407 there was a requirement included that stated the time frame between the first arriving medic and the second should be within 3 minutes or less 95% of the time. This has never been a requirement for any agency in the past. We also do not believe any agency within Los Angeles County could meet such a requirement. In the past if the first unit on scene was a PAU there was never any concern as to how long the PAU medic was operating prior to paramedic unit arriving. The chief concern was how long it took to get an ALS level care on scene. PAUs have been operating in Los Angeles County for many years without any concerns or issues in their operation. Prior to RMD, when we did have a PAU arrive in lieu of a BLS engine first, we had the second unit arrive within 3 minutes or less 79% of the time when we reviewed 2013 data. Since the inception of the RMD program that percentage has essentially remained unchanged. The second medic arrives

Administration
(562) 570-2510
FAX (562) 570-2506

Fire Prevention
(562) 570-2560
FAX (562) 570-2566

Operations
(562) 570-2530
FAX (562) 570-2564

Support Services
(562) 570-2501
FAX (562) 570-2556

within 3 minutes 79% of the time. If we look at the variance between the first arriving Paramedic and the second resource we show the following data:

2 Medics Onscene	Variance (2nd Onscene Clock - 1st Onscene Clock)
1/1/2013..12/31/2013	3:20
1/1/2014..7/1/2014	3:14
7/10/2014..10/10/2014	2:21

We believe a more accurate way to assess the RMD program is to evaluate its effectiveness by comparing how quickly we delivered two paramedics prior to RMD and comparing it to Post RMD. If we look at the same data set for 2013 and 2014 (see chart below) we show an improvement of 1:04 seconds on average.

The data is as follows:

2013	1 Paramedic	2 Paramedic
July 10-30	5:55	8:38
August	5:48	8:25
September	6:01	8:15
Avg Time	5:54	8:26
2014		
July 10-30	5:14	7:15
August	4:58	7:23
September	4:57	7:28
Avg Time	5:03	7:22

PLAN FOR IMPROVEMENT

As a plan for improvement we have already made some changes to our system to deliver the second paramedic to the scene quicker. They are as follows:

- We have added two peak load BLS units to the system. This reduces the overall call volume per rescue and keeps the RMD rescues available a higher percentage of the time for ALS responses. By transporting a higher percentage of ALS calls, it also reduces their wait times at the hospital.

Cathy Chidester, Director of EMS

October 28, 2014

Page 2

- We will also be adding a third peak load BLS unit to further help in this regard.
- We are more closely monitoring our dispatch data. We just started a more proactive approach in tracking our response times by instituting a program called "Firestat". Firestat allows us to track key performance indicators such as dispatch and response times to the Battalion Chiefs and Company Commanders using real time data directly. This will allow us to improve dispatch times by increasing accuracy and accountability. With the additional BLS units and Firestat reporting, we expect to see a better performance profile in the future.

Sincerely,



Michael A. DuRee

Fire Chief

cc: ✓ EMS Commission
DSMB
Medical Director, LBFD
Long Beach City Manager
Medical Director, EMS Agency



**911 EMS Provider Ebola Virus Disease (EVD)
Patient Assessment and Transportation Guidelines**



EMERGENCY MEDICAL
SERVICES AGENCY
LOS ANGELES COUNTY

5.7

Medical Dispatch, EMT or Paramedic determines if patient meets suspect EVD criteria

Fever, headache, joint and muscle aches, weakness, fatigue, diarrhea, vomiting, stomach pain and lack of appetite, and in some cases, bleeding

AND

Confirmed travel to West Africa (**Guinea, Liberia, Sierra Leone**) within 21 days (3 weeks) of symptom onset

If patient meets above criteria:

Implement recommended use of PPE against Ebola exposure during assessment, transport and treatment

- PPE - N95 mask in combination with surgical hood and full face shield or PAPR
- fluid resistant gown or coveralls without a hood that extends to mid-calf
- double gloves
- fluid-resistant boot covers that extend to mid-calf
- fluid-resistant apron if vomiting or diarrhea

IMMEDIATELY contact assigned base hospital and consult for further treatment needs and necessity for immediate transport to the MAR.
If patient's condition DOES NOT warrant immediate transport, 911 provider, in consultation with the base hospital, should contact Public Health from the field.

Consult with Public Health by calling ACDC:
(213) 240-7941 (Monday through Friday 8:00 a.m. to 5:00 p.m.) or
(213) 974-1234 (nights and weekends) ask to speak to Public Health AOD

- If Public Health confirms patient is a suspect EVD case:
1. Notify receiving hospital (MAR)
 2. Arrange ambulance transport through:

For Fire Departments utilizing **Exclusive Operating Area Ambulance Provider (EOA)**
American Medical Response, Care Ambulance, Schaefer Ambulance, and WestMed McCormick

OR

For Fire Departments needing transportation:
EMS Agency's Central Dispatch Office (CDO)
(866) 941-4401
Request for a High Risk EOA Ambulance

Effective:
2014-10-28

Provide the following information to EOA Provider or CDO:

1. Patient information (name, sex, patient location)
2. Phone number to contact the person requesting transport
3. Phone number for jurisdictional dispatch center



EMERGENCY MEDICAL
SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate and quality
emergency and disaster
medical services.*



Health Services
<http://ems.dhs.lacounty.gov>

October 29, 2014

TO: Emergency Department Manager
Disaster Planner
Each 9-1-1 Receiving Facility

FROM: Kay Fruhwirth 
Assistant Director

**SUBJECT: GUIDANCE ON TRANSFER OF CARE OF SUSPECT
EBOLA VIRUS DISEASE (EVD) PATIENT
TRANSPORTED BY AMBULANCE**

As discussed on the Hospital Ebola Planning conference call on October 29, 2014, the Emergency Medical Services (EMS) Agency has been working with the EMS Provider Agencies, both public and private, developing guidance on identifying Suspect EVD patients that access the 9-1-1 system, patient destination, the safe transport of these patients and the transfer of care upon arrival at the 9-1-1 receiving facility. Attached is a summary of those processes.

EVD is an emerging infectious disease and as the disease is better understood, changes and revisions to processes and procedures are sure to occur. The EMS Agency has set-up an Ebola section on its website that can be accessed at <http://ems.dhs.lacounty.gov>, please refer to this site for the most current information available from the County.

If you have any questions or concerns regarding the attached guidance document please contact me at kfruhwirth@dhs.lacounty.gov.

GUIDANCE ON TRANSFER OF CARE OF SUSPECT EBOLA VIRUS DISEASE (EVD) PATIENT TRANSPORTED BY AMBULANCE

1. 9-1-1 activated, patient screened based on chief complaint for symptoms consistent with EVD to include fever, headache, joint and muscle aches, weakness, fatigue, diarrhea, vomiting, stomach pain and lack of appetite and in some cases, bleeding. If any of these symptoms are present, then the patient is screened for travel history to the West African nations of Guinea, Liberia and Sierra Leone. If travel history is positive for travel to one of the above countries, then this patient is considered a suspect EVD patient.
2. The 9-1-1 providers don appropriate PPE, contact Base Hospital and consult for treatment. If the patient's condition does not warrant immediate transport, the EMS Provider Agency should consult with Public Health who will assist in making the determination if the patient meets the case definition for EVD patient.
3. Suspect EVD patients will be transported to the most accessible receiving (MAR) facility. If the Base Hospital is not the MAR, the Base Hospital will notify the MAR.
4. The MAR will make appropriate preparation to receive and isolate the suspect EVD patient, including protecting the workforce through the use of personal protective equipment (PPE).
5. Upon arrival at the hospital, the EMS Provider Agency will call the hospital to let them know they are in the ambulance unloading area. To avoid any contamination of the emergency department, the hospital staff, in appropriate PPE will take a gurney out to the ambulance. A protective cover (i.e. plastic sheeting, tarp, surgical drape) large enough (approximate size of 8'x10') to cover the area of the ambulance gurney when it is unloaded and the area the EMS providers are standing in, when unloading the gurney, should be placed on the ground to prevent contamination of the driveway.
6. The suspect EVD patient will be unloaded from the ambulance, EMS providers will remain on the protective cover, patient will be moved to the hospital gurney and report given to the hospital staff. The hospital staff will then move the patient into the hospital by the planned access route.
7. The EMS providers will stay outside of the emergency department and with assistance from other staff from their agency they will doff their PPE according to their agencies procedures. All used PPE will be bagged and placed in the back compartment of the ambulance.
8. The ambulance will be taken out of service and will be left at the hospital until the suspect EVD patient's Ebola lab test results are available (around 12 hours). If the patient is confirmed as having Ebola, the provider agency will work with the County to have their ambulance decontaminated and disposal of medical waste. If the patient tests negative for Ebola, the provider agency will dispose of all waste in the normal trash, clean the ambulance as they normally clean the ambulance between patients and put their vehicle back in service.



TRANSPORT AND HOSPITAL ADMISSION OF SUSPECT OR CONFIRMED EBOLA VIRUS DISEASE (EVD) PATIENT



SUBJECT: EVD Triage, Transport and Transfer to Ebola Specialty Center (ESC)

PURPOSE: To provide 9-1-1 providers, private ambulance companies, acute care facilities, Medical Alert Center (MAC), Central Dispatch Office and Public Health the procedure to transport suspect or confirmed EVD patients to a designated ESC.

DEFINITIONS:

1. **ACUTE COMMUNICABLE DISEASE CONTROL (ACDC):** Serves as the lead unit for surveillance and investigation of certain suspected and confirmed communicable cases and disease syndromes. Phone number: (213) 240-7941 (M-F 8AM-5PM) or (213) 974-1234 (after hours – ask for Public Health AOD).
2. **AMBULANCE PROVIDERS:** Exclusive Operating Area (EOA) Providers (American Medical Response, Care Ambulance, Schaefer Ambulance, and WestMed McCormick), have agreed to transport suspect EVD, quarantined and confirmed EVD patients.
3. **CONFIRMED EVD PATIENT:** Patient whose blood tested positive for EVD from LA County Public Health laboratory.
4. **EBOLA SPECIALTY CENTER (ESC):** Acute care facility that has agreed to and is capable of receiving PUI cases and suspect and/or confirmed EVD patients.
5. **SUSPECT EVD PATIENT:** Patient with a positive, confirmed travel history to Liberia, Guinea or Sierra Leone within the past 21 days AND where LA County Acute Communicable Disease Control (ACDC) actively following.
6. **QUARANTINE:** Separates and restricts the movement of well people who were exposed to a contagious disease for the duration of time of the longest incubation period (21 days for EVD) to see if they become sick.

GUIDELINES:

I. Triage and Transfer Criteria:

1. Suspect EVD Cases:
 - a. 9-1-1 patients will be transported to per the 911 EMS Provider EVD Patient Assessment and Transportation Guidelines
 - b. Patient may be transferred to an ESC after consultation with and requested by ACDC.
2. Confirmed EVD patient: Patient will be transferred to an ESC after consultation with and requested by ACDC.
3. Quarantined person:
 - a. Develops fever and/or other signs and symptoms compatible with EVD.
 - b. DPH field staff observes signs/symptoms of EVD and confirms case with ACDC physician.
 - c. ACDC requests patient transfer to ESC.

**TRANSPORT AND HOSPITAL ADMISSION OF SUSPECT OR CONFIRMED
EBOLA VIRUS DISEASE (EVD) PATIENT**

II. Patient Placement

ACDC Physician shall:

1. Arrange transfer of EVD patient to an ESC
2. Notify Emergency Medical Services Agency's Central Dispatch Office (CDO) of need to transport patient to identified ESC by calling (866) 941-4401.
3. Provide CDO the following:
 - a. Patient information (name, age, sex, race, date of birth, medical condition)
 - b. Current location of patient
 - c. Receiving hospital name and contact information
 - d. Receiving hospital transport team information, if applicable
 - e. Special instructions i.e. specific PPE requirements or patient care procedures.

III. Transport

1. CDO shall dispatch EOA ambulance to transport patient and inform crew to contact CDO directly via phone for specific instructions.
2. CDO will provide specific instructions to ambulance crew regarding specialized transport and needs.
3. Exclusive Operating Area (EOA) ambulance provider will respond with "high-risk ambulance" to transport patient.
4. EOA ambulance to provide transportation only. For advance life support transport, receiving hospital shall provide transport patient care staff.
5. EOA ambulance crew to document transport using established patient care records.